

Ophthalmology

The Retraction Syndrome

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It is important that this condition should be recognized because it is liable to be confused with a sixth nerve (abducens) palsy.

The retraction syndrome was first described by Sinclair in 1895. During the next decade several cases were recorded, but it was not until 1905 that Duane reported a considerable series and described the condition and its variations in detail. Since then it has been known as Duane's retraction syndrome.

Clinical Features

The condition may occur in either sex. In nearly 70% of cases the left eye is affected. The right eye may occasionally be involved, and less frequently both eyes may be affected. It is not associated with any particular type of refractive error, nor is there any commonly associated abnormality elsewhere in the body.

In the majority of cases no defect can be seen when the patient looks straight in front. Occasionally, however, there may be an internal squint of the affected eye. Less frequently the head may be held so that it is turned slightly towards the side of the affected eye in order to permit binocular vision. This occurred in the second of the two cases reported in this paper.

The characteristic features of the condition are as follows:

- (1) On adduction the affected eye is retracted several millimetres into the orbit and there is an accompanying narrowing of the palpebral fissure.
- (2) There is complete absence of abduction of the affected eye beyond the midline.
- (3) The range of convergence is usually diminished.

Additional features are sometimes found, such as elevation or depression of the affected eye on medial rotation. The two cases to be described did not exhibit these features.

It is interesting that these patients rarely complain of diplopia although it is usually possible to demonstrate diplopia by special tests. They learn to turn the head when looking to the affected side or to suppress the image of the affected eye whenever diplopia occurs. The visual acuity of the affected eye is often somewhat reduced. Examination for stereopsis shows that a few patients are able to appreciate stereopsis on looking to the front and to the side of the normal eye.

Pathology

In those cases on whom operation has been performed the lateral rectus has been found to be replaced by a fibrous band. Abduction is therefore impossible, but reciprocal relaxation of the medial rectus permits the eye to rotate to the midline. On adduction the medial rectus contracts, but there is no corresponding relaxation of the lateral rectus. The eye is therefore retracted into the orbit. Several cases have shown anomalous bands of fibrous tissue which account for the movements of elevation or depression of the affected eye on adduction.

The cause of this congenital condition is unknown, but a few familial cases have been recorded. Its predilection for the left lateral rectus is unexplained.

Differential Diagnosis From Sixth Nerve Palsy

(1) The retraction of the affected eye and the associated narrowing of the palpebral fissure on medial rotation are the essential features of Duane's retraction syndrome. They do not occur in sixth nerve palsy.

(2) Defective convergence occurs in the retraction syndrome, but excessive convergence accompanies a sixth nerve palsy.

(3) An acquired lateral rectus palsy causes disquieting horizontal diplopia. Diplopia is never the presenting symptom in the retraction syndrome.

(4) Duane's retraction syndrome is a congenital condition. Lateral rectus palsy may be either congenital or acquired.

Treatment

If the eyes are straight in the primary position no treatment is required. If, however, a convergent squint is present in the primary position, the eyes should be straightened by operation.

Two typical cases of the condition are recorded below:

Case I. Mr. E. L. McG. Age 31. (See Figure 1). This patient consulted me on September 8th, 1953, complaining of difficulty in reading. He was aware that the left eye would not look to the left, and stated that the condition had been present as long as he could remember. On examination his vision was R 20/20, L 20/20. His pupillary reactions and fundi were normal. He had a negligible refractive error, but his ability to converge was defective. On looking straight ahead he was able to fuse the images seen with each eye, but was unable to appreciate stereopsis. Diplopia occurred on looking to the left.

Case II. Miss E. D. T. Age 23. (See Figure 1). Dr. E. G. Brownell referred this patient to me because she was complaining of constant headaches, and on examination he noticed that the left eye was unable to abduct beyond the mid-line. She knew she was myopic, and had spectacles which enabled her to see R 20/60, L 20/80. On examination the pupillary reactions and fundi were normal. With a stronger optical correction she saw R 20/20, L 20/20. She tended to hold her head rotated slightly to the left, with eyes rotated slightly to the right in order to permit fusion of

Summary

Duane's retraction syndrome is described and its differential diagnosis from sixth nerve palsy is discussed. Two typical cases of the condition are recorded.

References

1. Sinclair, Ophth. Rev., 14: 314, 1895.
2. Duane, A., Congenital Deficiency of Abduction, associated with Impairment of Adduction, Retraction Movements, Contraction of the Palpebral Fissure and Oblique Movements of the Eye, Arch. Ophth., 34: 133-159, 1905.
3. Aebli, R., Retraction Syndrome, Arch. Ophth., 10: 602-61, 1939.

Duane's Retraction Syndrome In Each Case the Left Eye is Affected

Figure I

Case I



Case II



When Looking Straight Ahead No Defect Can Be Detected



On Looking to the Right there is Retraction of the Affected Left Eye with Associated Narrowing of the Palpebral Fissure



On Looking to the Left there is Inability to Abduct the Left Eye Beyond the Mid-Line

the images of the two eyes. She never saw double, and was able to suppress the image of each eye, but tended to use the right eye in preference to the left eye. Like the first patient she had defective appreciation of stereopsis.

I wish to record my thanks to Miss Marjorie Snell of the Children's Hospital for her reports on these two patients, and to Mr. John Kozie of the Winnipeg General Hospital for his excellent photography.

Congenital Abnormalities of the Ear

Harvey Lister, Winnipeg

In a discussion of any congenital defect some appreciation of the normal mode of development is essential, so it is intended to state, as briefly as possible, the outstanding facts in the embryology of the ear.

As early as the fourth week of intrauterine life, a thickening of the ectoderm, known as the otic placode, has been detected in the region of the first branchial groove. This placode becomes depressed below the general surface of the embryo and eventually becomes cut off from the surface ectoderm to form the otic vesicle, which soon buds off the endolymphatic duct and sac and differentiates into the various portions of the cochlea and vestibular apparatus.

At a later date, a cord of ectoderm grows inwards from the first branchial groove and becomes canalized from its medial end to form the external auditory canal and outer layer of the tympanic membrane, while the visible portion of the ear, or auricle, is developing by the fusion of six hillocks on the first and second branchial arches.

The Eustachian tube occurs originally as a diverticulum of the fore-gut, and is, therefore, an endodermal structure. Its lateral end expands to form the middle ear cavity and settles in a position between the two ectodermal structures described above. The auditory ossicles develop from the mesoderm of the first two branchial arches, the malleus and the incus from the mandibular, and the stapes from the hyoid arch.

Protruding Auricles

Probably the commonest anomaly is the simple protruding auricle. The auricle is normally set at an angle of about 20 degrees with the cranium. An appreciable increase in size of this angle renders the auricles abnormally prominent. All gradations of this prominence occur, from a few degrees of protrusion to a complete absence of the antihelix, causing the auricle to protrude at an angle of almost 90 degrees from the head. A marked defect on one side may be accompanied by a slight change on the other. The operation performed must be adapted to each individual case and can only be finally determined during the actual procedure. Basically, it is necessary to construct an antihelix; this is usually done by excising a portion of the cartilage and folding back the free edges to form a ridge, suitably modelled to prevent it having a too sharp and unnatural appearance. Redundant skin is excised from the auricle-cephalic angle and the edges approximated.

Photographs 1 and 2 are the pre-operative appearance, and 3 and 4 the appearance three months post-operatively, of a case treated by the above

technique in December, 1953. Note the absence of the antihelix in Fig. 1, and its construction in Fig. 3.

Figure 1



Figure 2



Figure 3



Figure 4

Pre-Auricular Sinus

The condition of pre-auricular sinus is one which is very often overlooked. In any recurrent or persistent infection anterior to the pinna the existence of a congenital sinus should be suspected. This is thought to result from an incomplete fusion of the embryonic tubercles mentioned above. The opening of the sinus is usually about the junction of the root of the helix and the tragus, and if probed, the tract will be found to run medially and slightly downwards and forwards. If the sinus becomes infected, a cyst will form at the medial end. If this cyst is incised, ulceration and scarring of the surface is liable to occur. I saw one case which had been treated thus recently, necessitating not only complete excision of the sinus, but also excision of an area of scarred skin and closure with atraumatic sutures. In another case which had not been touched previously, it was a comparatively simple matter to excise the sinus and the small cyst at its extremity.

Atresia of the External Auditory Canal

It will be remembered from our original discussion that the external canal develops as an ingrowth of ectoderm which eventually becomes lodged in contact with the other elements of the tympanic membrane and is then canalized from its medial end. If this process becomes arrested at any stage various degrees of atresia will result.

e.g.: there may be no evidence of any canal, or there may be a primary canal representing the first branchial groove, which can be seen to end blindly a few millimetres from the concha. Beyond this there is an unorganized mass of fibrous, cartilaginous and osseous tissue with a bony plate occupying the usual position of the tympanic membrane. This condition may be associated with faults in the middle and internal ear so that before any surgery is performed, the patient is subjected to complete air and bone conduction audiometry, tuning fork tests and x-rays of the temporal bone, in an attempt to ascertain the existence or otherwise, of an adequate hearing perception mechanism. In cases found suitable by the above investigations, a marked hearing improvement may be obtained by the surgical procedure to be outlined below, as demonstrated in the following audiogram.

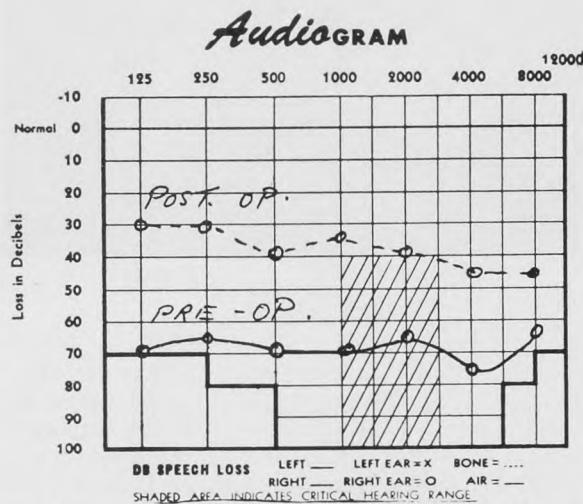


Diagram illustrates the improvement in hearing by air conduction following operation on the right ear in a boy aged 9 years.

It is possible, by proper posturing and exposure, to illustrate radiologically the semicircular canals, cochlea, and the auditory ossicles, and for the excellent prints shown here, I am indebted to Dr. Gilbert Roy Owens, of Los Angeles.

The correction of the atresia should be performed by one thoroughly accustomed to endaural surgical methods and the fenestration technique. An endaural incision is made and an external canal is created and eventually lined with a split thickness graft. The approach to the middle ear through the mastoid bone is carried out with more than ordinary care, because of the distorted anatomy. It has been stated by various authors that the facial nerve is often aberrant, but this has not been my experience. If the malleus and incus are fused, they should be removed and the mobility of the stapes tested. If the latter is fixed, fenestration of the lateral canal may be performed

at this, or a later operation. As a normal tympanic membrane is usually absent, it may be replaced by a skin graft placed over the middle ear structures. The skin grafting of the external canal is then completed and sea sponge packing inserted or, if desired, a stent mold may be used to prevent subsequent contraction of the newly constructed meatus.

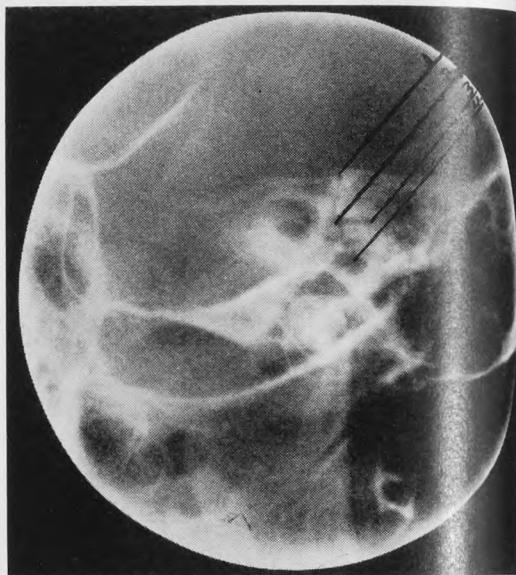


Plate 6 — This is a Stenver's view of the right petrotemporal bone in which (1) indicates the position of the superior and (3) the horizontal semi-circular canal meeting at the vestibule (2) in the shadow of which lies the head of the malleus; (4) points to the internal auditory meatus with the cochlea overlying in part.

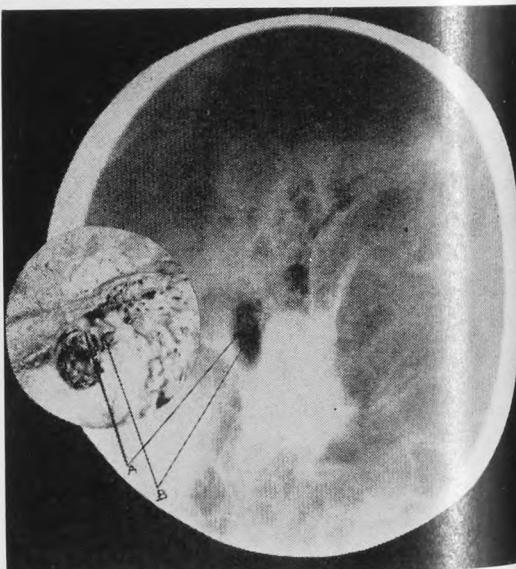


Plate 7 — The above illustrates photographically as radiologically the tympanic and epitympanic spaces with the malleus (A), and the incus (B) in position.

Microtia

The atresia of the external canal may be accompanied by any degree of microtia. In such cases

Medicine

Iodine

Its Use in the Treatment and Prevention of Poliomyelitis and Allied Diseases

J. F. Edward, M.D.

According to British Law, an individual is innocent until proven guilty. Applying the same legal dictum to Poliomyelitis its cause was adjudged, between 1905 and 1911, to be contagious and infectious; this, in the absence of a knowledge of its cause of spread, its only proven crime being that it could become epidemic. It was declared to be viral in origin.

This implication by the Public Health Laws of many of the Provinces of Canada and of the States of the Union made Poliomyelitis legally an infectious contagious disease, and thereby opened the door for research, considering the disease as such; and closed the door to research along lines other than that which has been publicised and financed by endowment in the past forty years. This situation finds the Medical Profession in this year of our Lord 1954 in a position to declare "We have no treatment for Poliomyelitis." Truly nursing care has improved, dating from the initiation of the Kenny Method of therapy, but methods of treatment or prevention of the disease are conspicuous by their absence.

Viewing the disease from a Clinical stand point, in Manitoba's Epidemics of 1952 and 1953 one notes that:

1. Few of our cases had a history of contact with an earlier case.
2. Few of our cases transmitted the disease to family contacts.
3. Few of Medical Personnel in attendance upon Polio patients acquired the disease or transmitted it to their families.
4. A state of fatigue frequently preceded the attack, yet many Medical Personnel working with these patients to a point of their exhaustion did not fall victim to the disease.
5. The disease is seasonal and may be Geographical.

Animal experimentation has truly shown the disease to be transmissible, but no single means of transmission in the human animal has been proven.

The fact that Polio is a Seasonal disease occurring in late Spring and Summer, places it in a class apart from practically all other infectious diseases, which are most prevalent in those Seasons when humans are confined within doors and congregate in groups. And the fact that epidemics fall off with the advent of cool fall days and nights, leaves one to consider if the then existing protection is

not linked with body function; probably with stimulation of Thyroid function.

An overall Geographic picture of epidemics would place Winnipeg as the Canadian Polio capital and St. Louis the American capital. A similar map drawn for Encephalitis in horses would correspond favourably with the polio map.

Viewing the problem of spread from the Geographic angle one is not a little surprised to see it compares favourably with our Goitre area. Could Iodine deficiency link in with Polio's so called infection?

Assuming this to be a fact and after confirming the assumption in animal virus diseases, in 1952 I treated three Bulbar Polio patients with intravenous Sodium Iodid. In these three, control of the disease was found to be most rapid and convalescence surprisingly brief. I was, at this time, convinced that the Iodides acted as a virucide, but the virucide theory was hardly tenable as the quantities used (grs. 7½) was hardly ample and the dosage was never given more than twice, and then three days apart. Further consideration and discussion brought forth from one of my confreres the suggestion that by the intravenous injection of Iodides I was stimulating a defense mechanism, the Iodides acting as a catalyst.

The 1953 epidemic was entered with this theory in mind. Numbers, and the varying severity of the disease, forbade intravenous therapy so I administered iodides orally depending on clinical examination for diagnosis, I having concluded in 1952 that spinal puncture only added insult to injury, with nothing gained.

The season advanced; Gamma Globulin stocks became exhausted; and my patients clamored for protection. Carrying the defence mechanism theory a step farther; "if I could control why could I not protect?" Of those seeking protection I formed an experimental group, giving one to three minims, according to age, of S.S. Pot. Iodide in milk daily for ten days (equivalent to 1.7 to 5 grains K1).

The season finally ended. I had seen some sixty cases. Two were sent to the King George Municipal Hospital because of the possibility of respiratory difficulties and lack of nursing care. The remainder were treated at home. Only one on home care developed paralysis, a paralysis that did not advance after oral Iodide administration. None of two hundred contacts on prophylactic therapy developed Polio. There were no deaths.

Can this theory fit our endemic cases and our Eskimo group? I believe it may. These people may be so low in iodine requirement as to have

little or no defence against the invader if such there be.

The use of iodides in the control of known virus diseases affecting the central nervous system is by no means new.

1. Manson, of England (1825) advocated its use in Palsies, many of which cases must have been Polio.

2. Coplan (1850) reports benefits in Palsy, derived from Potassium Iodide in dosages as small as grs. 1 in twenty-four hours.

3. Brown-Sequard (1861) recommended Potassium Iodide as the only known remedy that could be used without danger in various forms of Paraplegia.

4. Sinkler (1875) reported the treatment of an asthmatic with Potassium Iodide. The patient, who also had Polio, improved with the therapy.

5. Elliott (1885) employed and recommended Potassium Iodide in combination with other medications in Polio. Similar therapy was employed by Erb, Charcot and Hammond.

6. Webber in (1885) recommended its use in Polio.

7. Ridley (1925) employed Tincture of Iodine in the treatment of Beriberi, a paralytic disease genetically related, according to 8. Braddon, to poliomyelitis. Beriberi was at one time declared like Pellagra to be a virus disease.

9. Sir Thomas Horder (1927) reported the use of Colloidal Iodine intravenously in the treatment of Poliomyelitis. He recommended its early use.

10. Breuil and Dartiguenave (1937) after trial with chemo-therapy failed in Polio, reported improvement on iodine therapy.

11. Maberly (1939) reported complete recovery of four cases of Polio on iodine therapy.

12. Mazzitelli (1939) gave a teaspoon of iodine-tannic acid syrup twice a day for several days to children in families with cases of Poliomyelitis or in contact with them. None of these children who had preventive therapy developed poliomyelitis in that epidemic or in future ones. (Syrup Iodo-Tannicus contains (1.0%) Iodine).

13. Scoby (1946) suggested the use of Iodine in the prevention and treatment of Polio and 14. in (1948) pointed out that iodine combined with ascorbic acid and calcium produced improvement in some cases in twenty-four hours.

The present writer in 1944 discussed with Dr. Fahrni of Winnipeg the possibilities of using intravenous Sodium Iodide in Polio. Dr. Fahrni was then using Sodium Iodide, grs. 15, in 10 cc. distilled water (Park-Davis) intravenously in Thyroid Crisis. Dr. Fahrni assured me that if given slowly it could at least do no harm. Not until 1952 did the opportunity arise to use it, with the previously recorded results.

15. In 1948 I reported to the Canadian Medical Association Journal a report of a number of experiments with Iodine on humans and animals.

Iodine Therapy in Herpes Zoster

16. Head and Campbell (1900) described Herpes Zoster as "Acute Posterior Horn Poliomyelitis." In this disease the anterior horn cells have not infrequently been involved and paralytic manifestations and atrophy have been observed. Epidemics of Herpes Zoster have been reported. These epidemics have sometimes paralleled Polio epidemics.

17. Ruggles (1931) and 18. Beers (1939) reported early and dramatic relief of Herpes Zoster with intravenous Sodium Iodide.

19. Beckman (1953) approves the use of Sodium Iodide, Gms. 2 in 30 cc. of water intravenously at two day intervals for four or five treatments in Herpes Zoster.

Iodine in the Treatment of Encephalitis and Central Nervous System Diseases of Animals and Fowl

20. Lewitis (1935) states that Iodides have been used with surprising results in cases of inflammation involving the spinal cord and brain.

21. Brinton, a poultry man (1931) reported that leg weakness in his flock following the feeding of excess wheat was cured with iodized buttermilk. Later he prevented the leg weakness and also Coccidiosis with said buttermilk.

22. Grey (1940) used a 10% solution of potassium iodide in distilled water in the treatment of fowl paralysis (lymphomatosis). After the first injection the birds became brighter, after the second muscular tone was restored and the birds rapidly progressed to normal.

23. Radeleff (1946) employed intravenous sodium iodide in the treatment of equine encephalitis. In his group so treated the mortality rate was less than 10% with no "dummies." Dummies are animals that survive, but have permanent brain damage. In his control group the mortality rate was 40 to 50%. He reports rapid recovery and short convalescence in his iodide treated group.

McLoughry, a Manitoban Veterinarian, during the epidemic of encephalitis in the later thirties and early forties paralleled Radeleff's findings. He employed potassium iodide. His success prompted my experiment reported in 1948 in the prophylaxis of equine encephalitis.

It is worthy of note that a number of workers including 24. von Economo (1931) employed iodine in the treatment of human encephalitis with favourable results.

Last Summer Dr. Archie Kiteley of Nipawin, Sask., drew my attention to the fact that his area had no cases of human encephalitis during or since the epidemic years. This he argues may be due

to the fact that in the early days, while we farmers were battling our stock breeding problems, he and his confrere, Dr. Max Scott, recognizing the deficiency of iodides, prescribed sodium iodide in practically every prescription they wrote. Is it possible epidemics of Polio were suppressed by this very means?

25. In an editorial in the Journal of the American Veterinary Association the reports on the treatment and prophylaxis of equine encephalitis by Radeleff and myself are reviewed. In that editorial it is pointed out that 26. Holtman (1946) has made known his belief that there may be a relationship between the level of thyroid secretion and susceptibility to human poliomyelitis and encephalitis, due to the fact that these diseases occur in warm weather when natural secretions of the thyroid are the lowest.

Within our midst we may shortly have definite information to prove or disprove Holtman's belief. Dr. Brereton, Sr. is finding some startling data on thyroid function in children. And Dr. Elliott is conducting a survey in those areas of Manitoba which the Dept. of Health supplies with Iodides to prevent Goitre, to determine the incidence of Polio in those children on iodides.

Comment

A summary is here presented of the uses of Iodine in treating Poliomyelitis and other central nervous system fevers in man, animals and birds. Its use in Polio is viewed with definite doubt by a large portion of the Medical Profession and this with reason, for so many theories of therapy have failed, even our hopeful Gamma Globulin being questioned, not without reason.

My personal opinion is that Iodine restores to normal a function probably thyroid in origin, which produces a chain reaction of defence and the patient is made to develop his own Gamma Globulin or its counterpart. I do not ask you to accept my theory without reserve until I have delivered further proof. I am planning, should Manitoba have a Polio epidemic in 1954, to place an experimental group of 10,000 on prophylactic therapy. May I ask your sympathetic observation and your extension of the experiment if you see fit.

I am in my own mind convinced that Iodine constitutes a prophylactic means against Polio; that its use in the treatment of Polio tends to restore muscle tone early and reduces convalescence to a minimum. Its use as a prophylactic could be extended to large areas by using the present system employed by Provincial Health in Goitre areas. This would bring the third Halogen, Iodine, into the field of Preventive Medicine with Chlorine and Fluorine.

Appreciations

27. To Dr. R. R. Scobey, 1411 South Salina St., Syracuse, N.Y., I extend my appreciation. I have used his article in the Archives of Pediatrics, 68, 1951, as my guide in tracing the Medical uses of Iodides in human therapy. I have indulged possibly in plagiarism in my quotations from his article. My only regret is that he does not quote his own cases. He may have been in a position not dissimilar to my own from 1944 to 1952 when I had no cases.

To Dr. Isa, of the Veterinary Department of the University of Manitoba, I am indebted for research of Veterinary Medical Literature.

To Dr. Ormerod of the Manitoba School of Medicine, I am indebted for discussion and constructive criticism. He is responsible for the formulation of the protective mechanism theory.

To my best of all wives I am indebted for her patience in reviewing my records and assisting in my experiments. Her observations were most valuable.

To my patients who submitted to experimental therapy, I am indeed indebted.

References

1. Manson, Alexander: Medical Researches of the Effects of Iodine in Bronchocoele, Paralysis, Chorea, Scrofula, Fistula Lachrymialis, Deafness, Dysphagia, White Swelling and Distortion of the Spine. London, 1825.
2. Coplan, James: On the Cause, Nature and Treatment of Palsy and Apoplexy. Lea and Blanchard, Phila., 1850.
3. Brown-Se'quard, C. E.: Lectures on the Diagnosis and Treatment of the Principle Forms of Paralysis of the Lower Extremities. J. P. Lippincott & Co., 1861.
4. Sinkler, W.: Am. J. Med. Sc. 69: 348-365, April, 1875.
5. Elliott, G.: Am. J. Med. Sc. 89: 138-146, January, 1885.
6. Webber, S. G.: A Treatise on Nervous Diseases—Their Symptoms and Treatment. p. 200, 1885.
7. Ridley, H. W.: J. Trop. M. & Hyg., 28: 102-103, March 2, 1925.
8. Braddon, W. L.: The Causes and Prevention of Beriberi, 1907.
9. Horder, Sir Thomas: Lancet, 1: 340-341, Feb. 12, 1927.
10. Breuil & Dartiguenave: Bull. Soc. Med. Chir. de L'Indochine, 15: 803, August-September, 1937.
11. Maberly, J.: The Health of the Nation and Deficiency Diseases, 1938.
12. Mazzitelli, M.: Studium, 29: 73, April 1, 1939.
13. Scobey, R. R.: Arch. Pediat., 63: 322-354, July, 1946.
14. Scobey, R. R.: Arch. Pediat., 65: 131-166, March, 1948.
15. Edward, J. F.: Can. M.A.J., 58: 210, February, 1948.
16. Head, H. and Campbell, A.W.: Brain, 23: 23, 1900.
17. Ruggles, E. W.: Arch. Dermat & Syph., 23: 472-476, March, 1931.
18. Beers, N. T.: J.A.M.A., 112: 2553, June 17, 1939.
19. Beckman, H.: Pharmacology in Clinical Practice, p. 257 1953.
20. Lewitus, Victor: Vet. Med., 31: 29-33, January, 1936.
21. Brinton, W. R.: Quoted by Chidester, F. E.; Ashworth, A. M.; Ashworth, G. A. and Wiles, T. A.; International Clin., 3: 63-72, September, 1934.
22. Gray, E.: Vet. J., 96: 28-34, 1940.
23. Radeleff, R. D.: J. Am. Vet. M.A., 109: 129-132, August, 1946.
24. von Economo.: Encephalitis Lethargica, London, 1931.
25. Editorial, Vet. Med., 37: 6, January, 1942.
26. Holtman, F.: Science, 104: 50-51, July, 1946.
27. Scobey, R. R.: Arch. Pediat., 68: 309-321.

Medical History

J. C. Hossack, M.D., C.M. (Man.)

The Third Book of the Chronicles of The Medical History Club Chapter III

1. Now when the days were accomplished that the brethren should come together, they gathered as was their wont in the House of the Physicians.

2. And there they did break bread and eat until they were sated.

3. And it was a goodly company that foregathered, yet was I, John, the scribe, not of them for like Peter's wife's mother I lay sick of a fever.

4. Yet they who were present spake afterwards unto me and so I learned from them what I now write.

5. And he who discoursed unto them was Ross called Mitchell, the same that is ruler over us; and it was needful that some other be chosen to sit in the high place while he spake.

6. And the lot fell upon Fred surnamed Young and who in sooth ageth not.

7. Then Fred arose in his place and bid Ross stand forth and say his say which he did and all who were there gave ear unto him as he spake.

8. Now the matter whereon he spake was one that came close unto us for it concerned the doctors which had aforetime been servants unto the Company of Adventurers which traded into the Bay of Hudson.

9. And Ross called Mitchell spake first of the Society which is called Royal and whereof the founders were learned and curious men, and physicians were among them.

10. And among the Fellows of this Society was the King's Majesty himself and also his cousin which was the Prince Rupert, to whom and to his company the king gave that land which we now inhabit; and this he did by the enactment of certain laws.

11. And the Prince gathered unto him others even to the number of thirty whereof eleven were fellows of this society and these formed his Gentleman Adventurers; and the company liveth even unto this day.

12. And Ross called Mitchell spake about certain physicians who were servants of the Prince's Company.

13. Now all that was said will in due season be set forth in writing so that all men may know the words of the discourse even as they were spoken.

14. But it is fitting to set down at this moment certain things, for some of these physicians were indeed adventurers who risked much upon the throw of the dice or the turn of a card.

15. And so it came to pass that search was made for sober men and industrious the which were to be found chiefly by His Majesty's Kingdom of Scotland.

16. For the Scots are a God-fearing people and mighty in good deeds.

17. Now many more things did Ross tell unto the company, and when he had made an end of his speaking the brethren questioned him upon the matter.

18. Yet what they asked I know not, nor how they were answered.

19. But they were much pleased and there was a great clapping of hands ere they departed.

20. And when certain of the brethren told me these things I meditated within myself.

21. And I thought upon the courage of these men who went forth upon the deep waters and into strange lands seeking new knowledge.

22. Yet went they not alone for knowledge but also for merchandise wherewith they might grow rich in this world's goods.

23. And I thought likewise of the manner whereby they got this wealth which was the capturing of little animals so that they might be killed and stripped of their skins.

24. And lest the skins might be damaged these creatures were caught in gins and snares wherewith they were held in torment for many days. And is it done even unto this day.

25. And I thought of the cruelty of man who doeth these things, and of the exceeding great cruelty of women whose craving for the skins of animals driveth men to go forth into the wilderness to hunt and kill for their adornment.

26. Yet so hath it been since the beginning.

27. Yea, verily, where would man be were not for woman?

28. One beareth him and bringeth him to manhood; and another then taketh him and leadeth him from thence onwards.

29. And thousands grow rich by satisfying their desires; and thousands grow poor in like fashion.

30. And were it not for women there would be little profit in our calling even as there would have been none for those adventurers whereof we have spoken.

31. And there came unto me another thought concerning the Society whereof I have spoken.

32. For it was held up to scorn by one who was a priest but in whose heart was the bitterness of gall.

33. And this priest wrote a book wherein he told of great marvels which he gave out that he had seen in strange lands.

34. And this he did in derision and in bitterness of spirit for verily all men were hateful unto him.

35. Now the name of this man was Jonathan and verily as I meditated upon the matter I was moved to pity albeit he wrought his own misfortunes.

36. Yet what man of himself bringeth about his own destruction? Verily none, for all are as clay in the hands of the potter.

And it cometh to pass when the hands lack skill that that which they mould is misshapen and unsightly.

37. And so was it with Jonathan to his grievous loss.

38. Now concerning the book say I nought save that it is for all to read, yea, even little children. And, verily, it is read most often by them for their fathers see not the meaning.

39. But say: Is it not about giants and people of exceeding small stature and of horses that do behave as men?

40. Therefore see they not what lieth beneath the words, but the words only.

41. And I was moved to think upon Jonathan and how his days came to their end which was in this wise.

42. Now it came to pass that Jonathan could no longer hear and would fall to the ground because of a lightness in his head. And he feared greatly that his reason would depart from him.

43. And it came to pass one day that Jonathan was seen to be gazing upon a tree the top whereof had been blasted. And one who saw him spake unto him saying: Wherefore dost thou look upon the tree in that fashion?

44. And Jonathan answered him saying: Verily I fear that it will be with me even as it hath been with the tree and I shall in like fashion be blasted.

45. Now it came to pass that Jonathan became blind and there came a swelling upon his eye so

that he saw not. And great was the pain thereof and fain would he have plucked forth his eye and cast it from him. And this he sought to do.

46. Therefore were men set by him even to the number of five and they held him, for great was his strength.

47. And this they did both by night and by day for he slept not for the space of a month.

48. Nor could the physicians heal him. And so he waxed weaker in body and in mind and gave up the ghost.

49. And I meditated upon these things and was saddened by my thoughts.

50. For verily there cometh unto every beast and to every man a time to die. The little creature dieth in torment in the gin that hath been set for it.

51. And he that setteth the snare falleth into another which likewise tormenteth him even more grievously for the animal knoweth not of death as doth man and therefore suffereth not from the thought thereof.

52. And to some Death cometh speedily, but to others it creepeth so slowly that they to whom it cometh cry out for it to hasten its pace yet will it not, even as it was with Jonathan.

53. But on these things it is not fitting that we should dwell for verily our art hath taught us how to vanquish many diseases and how to give ease unto the distressed in mind.

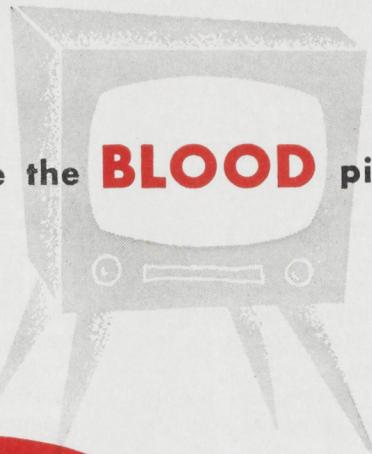
54. Peradventure had Jonathan lived in our time his burden would have been lightened for him.

55. Yet had that been so peradventure, likewise, he would have died twice. For now his memory liveth forevermore.

56. And so might it not have been had he been rescued from the gin of Fate. For, from the hardness and hardships of life there come the soft furs and the works that die not.



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Children's Hospital, Winnipeg

Ward Rounds

Edited by Wallace Grant, M.D.

Recent Experiences With Recurring and Overwhelming Infection

Case Presentations at Ward Rounds, Oct. 15th, 1953

Chairman: Dr. M. McLandress

(1) Presented by Dr. P. Barsky

This boy of five years (No. 53-2092, D.H.) first came into hospital in November, 1952. The mother then reported that she had noted nothing unusual until two nights before when she found him lying at the bottom of a flight of stairs. He had lost consciousness but she felt he had done no harm to himself. The next morning he appeared to be normal except that he ran a temperature. He was kept in the house, and nothing further was noted until the next day when he began to complain of severe pain in his right ear and the mother noticed that it was discharging. The next night he awoke, complaining of severe pain at the top of his head and his temperature was close to 103°. The headache persisted, he began to vomit and he was brought to hospital.

Physical examination at that time is reported as follows: "A 4½ year old boy, almost opisthotonic, with reflexes hyperactive, and semicomatose." On examination of a smear of cerebrospinal fluid, pneumococci were seen and he was consequently treated for pneumococcal-meningitis. This included intravenous fluid therapy, penicillin and sulfadiazine which was later supplemented by aureomycin. Within 36 hours he responded and clinically appeared well. He was in hospital for 12 days, and had several lumbar punctures which yielded fluid which was sterile on smear and culture.

We heard nothing more of him until the 5th of February of this year (1953) when he was readmitted with a very similar history except that this time it was the left ear which was discharging. Again pneumococci were readily demonstrated in the smear of his spinal fluid, and treatment was with what we felt were large doses of penicillin and sulfadiazine. He had X-ray films taken of both mastoid areas, and the whole spine, but nothing abnormal was revealed. Again he made a rapid recovery so that even a day after admission it was hard to believe that he could have been so ill 24 hours before. His course in hospital then was similar to that at the time of his first admission and he was discharged on March 2nd.

On March 23rd, 1953, he presented again with discharging ear, neck retraction, and other meningeal signs, and the same positive findings in the C.S.F. He was again treated intensively as before,



with penicillin 1,000,000 units every two hours for the first week, and intravenous sulfadiazine. This time we refrained from using any other drugs and his response was as rapid as before.

He was also seen by Dr. Parkinson who carried out oxygen encephalography which revealed no evidence of such abnormalities as a subdural lake or effusion. He was thoroughly examined for the presence of dermal sinus but, as before, none was found. In short we were quite unable to discover the source from which the pneumococcal infections spread to the meninges. He was discharged again clinically well on April 20.

The fourth admission was in May. Since there was now cloudiness evident in the right mastoid area, before his discharge he had a simple scraping of the right mastoid. An adenoidectomy was also performed because of the possibility that enlargement of the adenoids was, by obstructing the eustachian tube, contributing to the recurrence of otitis. During his 5th hospitalization (July 5-18) there was no evidence of ear infection, but again bacteriological evidence of pneumococcal-meningitis. On this occasion as before, the response to therapy was prompt, with clinical recovery within 48 hours.

Last week he was admitted for the sixth time in much the same condition as before and with similar laboratory findings. He is being treated as on previous admissions, but we are presenting him today because we are definitely at a loss to explain the source of the infection and the reason for its recurrence.

Dr. McLandress: "There are a few points I would like to bring out about this condition. In the first place pneumococcal-meningitis is extremely rare, and secondly I think we have been very fortunate in being able to tide this boy over several bouts, and have him remain as well clinically as he appears to be now. He has no hemiplegia and no other permanent neurological residue. The mortality rate for pneumococcal-meningitis remains the highest, in our experience with purulent-meningitides in this hospital (the coccal group at any rate), and the good result here

is due to the prompt handling he has received. I wonder if we could present the other boy who also poses a bacteriological problem and then we can discuss them both together."

(2) **Dr. Grewar**

(Case No. 53-2909—D.M.). "This eleven year old boy, who was admitted to hospital on October 7, presents both a diagnostic and a therapeutic problem. He was one of those children admitted to King George Hospital as "suspect polio" and found to be suffering from some other disorder. His first illness was in 1944, when he had a series of nose bleeds. He was admitted to St. Boniface Hospital at that time and was treated with nasal packing and blood transfusion. His platelet count was normal. When he had a second bout of nose bleeds he was again treated conservatively and everything went well until 1950 when he seemed to have been beset by a series of misfortunes. Early in that year he was admitted to St. Boniface Hospital with definite lobar pneumonia, but also had enlargement of spleen and liver and a profound anemia. This was a normochromic normocytic anemia. There was a satisfactory response of the pneumonia to penicillin therapy. When attention was turned to his anemia and enlarged spleen it was found that he had a platelet count of about 27,000. The bone marrow was hypoplastic with a normal number of megakaryocytes, but the impression was that they were not forming platelets. There was also some generalized lymphadenopathy, and biopsy of a node showed a non-specific picture. A diagnosis of hypersplenism was made and a splenectomy was carried out. Following the splenectomy his platelet count rose and during the next three months remained at a level between two and three hundred thousand, (once it rose to 800,000 and on two or three occasions it went as low as 60,000). This should have been enough for anyone in one year, but towards the end of 1950 he was re-admitted to St. Boniface Hospital with pneumococcal meningitis. This was treated with penicillin, aureomycin and a sulfonamide, in spite of which he had a relapse and recurrence. Following recovery from the second attack of meningitis he had almost total deafness (although there is a little hearing on the left side), a right-sided hemiparesis, and some dysarthria. An oxygen-ventriculogram was carried out in two occasions and it demonstrated some doubtful enlargement of both ventricles. There was no evidence of a space-occupying lesion.

"Progress following this illness was fairly good. He went to school on the morning of October 5th, 1953, his usual self, but toward evening he began to say peculiar things and acted in a delirious fashion. He was put to bed, vomited twice, was obviously feverish, and somewhat drowsy. In the morning he was no better and when visited by the

family doctor, was found to have some stiffness of the neck, and he was transferred to the King George Hospital as a suspect polio. On admission to the King George he was desperately ill, cyanosed, with a greyish pallor, he actually seemed close to death. His blood pressure was about 50 mm. systolic, and he was breathing in a shallow fashion. The combination of neck stiffness and shallow breathing suggested at first that he might well have polio, and he was in fact, put in a respirator. However, a lumbar puncture showed a spinal fluid that had some red cells but no white cells, and the protein was normal. He was treated heroically there, and I have no doubt that they saved his life.

"It was found that the respirator made little difference, and they suspected that he might have some suprarenal failure, so treated him using two intravenous drips with clear fluids and plasma, with noradrenaline in the form of "Levophed" all of which was effective in raising the blood pressure. In spite of being so obviously shocked he was able to indicate the fact that he wanted a drink, and he was able to move his limbs. Further investigation at the King George Hospital yielded the following information: Hemoglobin 15 gm%; Leukocyte count on admission —3000/cu. mm; Platelets were 27,000/cu. mm. The bleeding time was normal, the clotting time was delayed and so was the clot retraction. It was suspected that he had some bleeding diathesis and that he had possibly bled into his suprarenals. He was given cortisone — 100 mgm. stat and then 50 mgm. every 6 hours by intramuscular injection, then penicillin 300,000 units, followed by 100,000 units every 3 hours. During his stay at the King George Hospital he developed fairly large ecchymotic lesions, especially on his limbs, and also around his neck in the region of the respirator collar, the residue of these lesions being still faintly visible.

"He was transferred to the Children's Hospital the following day in considerably better shape than he was on admission to the King George Hospital. We continued the intravenous drip for 24 hours, put him on oral cortisone (25 mgm.) every 6 hours, stepped up the dose of penicillin and gave it a little less frequently. He continued to improve, and his temperature slowly fell. We now had a report on the blood culture which had been taken at the King George Hospital, and this was "no growth." We proceeded with the investigation of his hemorrhagic tendency, but on the third day after his admission here, he was not in such good condition, he became drowsy, his neck became stiff, and he was not drinking well. His white cell count had risen after the second day and had remained at about 30,000/cu. mm., and the platelet count was still below 50,000/cu. mm. Spinal fluid obtained by lumbar puncture reveals the presence of 190 cells, 90% polymorphs. There

were a few red cells in the fluid and it was slightly xanthochromic. We were unable to decide if this represented an early bacterial invasion of his central nervous system, with the few red cells and xanthochromic appearance as evidence of bleeding into his subarachnoid space similar to that occurring in other parts of his body, or if, in fact, it represented a traumatic tap (the large number of white cells being accounted for by the relatively high white cell count in his blood). At any rate, in spite of the fact that he had a blood dyscrasia, I felt that the wisest course was to put him on chloromycetin since it alone of the wide range antibiotics easily penetrates the blood-brain barrier. Blood was taken for culture at the same time as the lumbar puncture was done, and the findings will be reported by Miss Norris. Now I wondered if infection were proceeding apace aided by cortisone, and since his serum sodium was normal and his blood sugar was normal, I felt reasonably safe in stopping the cortisone. With chloromycetin, and an elevated dose of penicillin, he responded in 24 hours, blood culture then being sterile, and the C.S.F. grew nothing. Apart from the fact that he has needed some aid in his fluid intake for a day or two by intravenous means, he has continued to improve. He has a little herpes of the lips and lymphadenopathy is still present but the nodes are less tender.

"In resume one felt that this child had thrombocytopenia, and possibly the hemorrhagic tendency was set off by infection, possibly he bled into his suprarenals (I can think of nothing else to explain the shock picture since he had no massive hemorrhage anywhere else), and possibly the cortisone allowed the infection to run wild, for he undoubtedly had septicemia which has responded to the penicillin or chloromycetin."

Miss Norris: "Penicillinase was added to the blood culture and 24 hours after it was taken there was a massive growth of a Gram positive coccus which on subculture proved to be *Streptococcus Viridans*. It was grown on thioglycollate broth and blood agar. The C.S.F. showed no growth on culture. From the second blood culture nothing has grown so far."

Dr. McLandress: "Were sensitivity tests done?"

Miss Norris: "Yes, the organisms seem to be sensitive to chloromycetin, penicillin and terramycin."

Dr. Israels: "We're very fortunate in having with us today a distinguished investigator in the field of bacteriology, and therapy, in the person of Dr. Gajewski of the Parke Davis Co. We are presenting these two cases especially today to provide him with a basis for discussion of therapy in bacterial infection."

Dr. Gajewski: "Thank you very much, I would like to point out at the start that I am not a

Pediatrician, but I am interested in this particular field of infections in general. It is interesting that in the first case we have a demonstration that repeated courses of penicillin in pneumococcal infection lead to no particular resistance developing on the part of the organism. It seems that the *Staphylococcus* is unique insofar as the development of resistance is concerned. Apparently the sensitivity has remained high, since he responds so rapidly. I am in agreement with the speaker who suggested that perhaps this was originally a case of under-treatment. A good example is subacute bacterial endocarditis—where the clinical signs disappear so rapidly with intensive therapy, the blood culture becomes sterile, but the individual still has subacute bacterial endocarditis, and if therapy is not continued for an extensive period of time there will be recurrences of clinical signs and symptoms. In that case we know where the organisms are but we simply cannot get at them unless we use high concentrations of antibiotic over long periods of time. I have recently seen a patient with a rather unusual type of brain abscess, producing a picture somewhat like this. It was due to a *Borrelia* infection, with brain abscess and repeated attacks of meningitis. The organism was very sensitive to penicillin and no other antibiotic. Courses of penicillin gave temporary relief but, until intensive therapy was instituted and the abscess localized enough so that the neurosurgeons could open it up and clean the area out, the attacks continued. I wouldn't have any particular idea what the source of the infection in this instance is, I think there have been some very interesting comments and suggested possibilities. Brain abscess is certainly a very definite possibility, but one must also consider the possibility that injury to the cribriform plate allows spread upward from the nasopharynx. It is possible that this is just a case of continuing re-infection, but I suspect that there is a focus somewhere which has to be completely eradicated. Probably the only means of doing this would be by maintaining extremely high levels of penicillin over a long period of time, depending on what the particular sensitivity of the infecting organism is.

"The second case is, of course, of very much interest to us because this particular individual has received therapy with chloromycetin even while he had a blood dyscrasia. This is, of course, not the only instance that we have seen where this has been done. When one has an organism which is sensitive to a particular antibiotic, heroic treatment using that antibiotic seems justified even although there may be a remote possibility that there is some association between the use of the drug and the development of certain blood dyscrasias. We have, for instance, managed a few cases of aplastic anemia in which there was an

intercurrent infection, with intensive chloromycetin therapy, without in any way altering the picture of the aplastic anemia. Both of these instances were followed by recovery for a period of time, but with the aplastic marrow, the outcome was certain, and within a matter of several months the disease ran its course. However it was demonstrated that it was possible to combat an intercurrent infection in such a patient using chloromycetin."

Dr. McLandress: "Thank you very much Dr. Gajewski. It is very interesting to hear of the use of chloromycetin in the presence of blood dyscrasias."

Dr. Grewar: "His platelet count has risen now to 100,000."

Dr. S. Israels: "That's probably due to the chloromycetin!"

Dr. Graf: "I saw this child when he had his first meningitis. I saw him on the third or fourth day, and I recall that for the first 48 hours all he had had was procaine penicillin in the usual dose of 300,000 units a day. Following recovery he was completely spastic and couldn't talk at all for months. I'm amazed to see him now, doing as well as he is."

Question: "Is the diagnosis here a dyscrasia—that is, a primary thrombocytopenic purpura, idiopathic, or is there a possibility that this is an immune response?"

Dr. McLandress: "I don't think we can say at the moment, it would certainly appear that with the rising platelet count following the treatment of the infection his response to stress is a fall in platelet production."

Dr. Grewar: "A bone marrow examination was done this morning by Dr. Hoogstraten."

Dr. Hoogstraten: "It is a cellular marrow. It shows some granulopoietic hyperplasia and he has numerous megakaryocytes, but I would hesitate to state whether they are increased or decreased."

I don't think one can do this with any degree of accuracy since with bone marrow smears from normal people, some show no megakaryocytes, others having large numbers of them. On examination of this bone marrow, I can see no reason why he has a thrombocytopenia.

Dr. Ross: "With this first little boy I think we are overlooking the local treatment, with all this emphasis on general treatment which is certainly important. I would like to ask if, when he comes in as seriously ill as he is, does he have any local signs (either on clinical examination or electrically) which can be detected then or in the next few days when he starts to improve? Is there ever anything localizing, or are all the signs constitutional? Of the conditions which will produce a chronic or recurrent meningitis (with the exception of one or possibly two), they all produce more or less paramount local signs in their natural history, and as the history is modified by spasmodic antibiotic therapy. I think of osteomyelitis of the skull which this boy certainly doesn't have extradural abscess which he probably doesn't have, cortical venous thrombosis which he couldn't possibly have, brain abscess which he could not possibly have, for a dozen reasons—but a chronic bilateral otitis media certainly must be very important, and I would say it's as important to do radical surgical cleaning out of both mastoids as to give 60 days of intensive penicillin."

Dr. McLandress: "These presentations serve to emphasize again the need for careful thinking about the treatment used in bacterial infections."

Additional Note:

The boy (D. H.) was placed on 2 million units oral penicillin G, per day, after his sixth bout of meningitis. This was discontinued, without medical consent, on April 6th, 1954. The child was readmitted to the Children's Hospital on April 11th 1954, with his seventh attack of pneumococcal meningitis.

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Editorial

J. C. Hossack, M.D., C.M. (Man.), Editor

The Iniquity of Oblivion

"The iniquity of oblivion blindly scattereth her poppy and deals with the memory of men without distinction to merit of perpetuity." — Browne.

Among the distinguished gentlemen who are honorary members of our Association is Dr. Alfred Cox, long time General Secretary of the B.M.A.

The other day I came across a letter from him in which he writes: "I am glad to see the interest taken in Canada in Medical History. I read with great interest your own articles on the subject, but must confess to an even greater interest in those which deal with the pioneers in Canadian medicine. There is always the risk of these being forgotten."

Alas, it is not a risk—it is a certainty. Our Medical College was established in 1883—seventy-one years ago, well within the life-time of many now living. And yet not one of the students who attend there, nor any member of the Faculty, I make bold to say, could name the founders.

Recently on a visit to the library I saw what I took to be a large picture with its face to the wall. I turned it and saw the mounted photographs of the men whose materialized vision was about me. I looked at the faces through the thick veil of dust that covered them; surely, I thought, we are ungrateful so to dismiss them.

Once the halls in the College were lined with large class photographs. Not only did these serve to hide the bareness of the walls but idle students would look with interest on the youthful likenesses of their predecessors in this same building and find among them the names of those by whom they have been attended and of others by whom they were being taught. And among them, also, they would see the names of men who have become eminent and whose faces, linked with their achievements, gave inspiration.

Perhaps as class succeeded class the walls could no longer supply accommodation and all were banished so that no one might be offended. But the founders should not have been treated in the same fashion. To be sure their monument is all around us, but would they not wish to be remembered also by their features and by their names? Instead of being hidden obscurely in the dust their portraits should occupy a position of honour and prominence where students can see the features of the men to whom they are indebted and of whom they can be proud.

Thucydides began his history of the Peloponnesian War with these words: "Thucydides, an Athenian, wrote the history of the war between

the Peloponnesians and the Athenians, beginning at the moment it broke out, and believing that it would be a great war and more worthy of relation than any that had preceded it."

What a pity that someone did not undertake to play Thucydides to our College! There was a similar reason. In their minds' eye the founders saw something great, not only in structure but in quality and influence. And to them, as to us, is it not "more worthy of relation than any that has preceded it?" For here was something that was and is being made and formed by their, and by our, own hands. Tradition was not being added to. It was being made. Ancient universities which count their years by centuries give lustre to their students. Here, in our youth, it is for the students to make their school illustrious—a challenge that spurs—or should spur—their to achievement.

But no one then or since has seen fit to put in writing the story of how and by whom the idea was conceived, of the early difficulties and disappointments, of the internecine strifes that, like little wars, disturbed the School's peaceful progress of the circumstances which led to each of the great changes that mark its history. Dates of extraordinary importance stand up like megaliths upon a plain. But there are not many of them and these are almost uninscribed so that we infer rather than know what led to the events they commemorate.

During his lifetime the late Dr. E. W. Montgomery was urged to record the story he knew so well and so completely for he spanned the whole period from conception to absorption by the University. But he died and his knowledge died with him. Now no one can speak of these early days. Something can be gathered from minutes of meetings. But these are usually incomplete. They are the bare bones thinly clad. The discussions, the heated arguments, the harmonies, the open and concealed animosities, the bold decisions, the struggles between individuals, between factions and between hospitals, the brave adventures, the actual and threatened disruptions—all these which were the spirit, the living thing within the College—go unrecorded unless there be some hidden diaries that time will bring to light.

Young people, young countries, young institutions, do not tend to be historically-minded. The past becomes important only in proportion to its length. In youth it is the future that claims attention—not even the present is of great importance. Yet the future grows out of the past

as a branch does from a trunk.

But as time lengthens curiosity grows about the past. Already we would like to know more about what happened a life-span ago. A century, five centuries, hence what we can tell will eagerly be read, and still more eagerly would be read the story we cannot tell.

One of the purposes of the Medical History Club, now a section of the Winnipeg Medical Society, was to establish in the College a shrine, as it were, where records, instruments and other personal items of our pioneers might find a place. And what have we? The portraits of the founders with their faces turned to the wall, nameless and forgotten. They are dead and "the dead know not anything, neither have they any more a reward, for the memory of them is forgotten."

It is a pity. Surely they deserved a better fate.

Honour Where Honour Is Due

Elsewhere you will find the Address delivered by Dr. P. H. McNulty as his last official act in his capacity of Chairman of the M.M.S. We all owe a great deal to Dr. McNulty and those over whom he presided. The Medical Service Building is part of that debt.

But in remembering those who were in office when the building was erected, we should not forget those by whom it was first envisioned. The present scheme is the out growth of plans laid while we were still in the penumbra of the Depression. The Depression brought into being the Medical Relief Plan. The fees allowed by a careful, if not miserly, City Council were very small. Confinements brought the obstetrician only \$10.00. No operation cost more than \$50.00 and few were so expensive. An office consultation was valued at a dollar, and twenty-five cents was the fee for seeing a patient in hospital. No doctor might claim more than \$100.00 a month unless the circumstances were exceptional.

Inadequate as was the recompense it was at least some recompense and slight though it was, it was obtained only after long and tedious negotiation. And so did we rejoice at our victory over those who at first denied our claims that a banquet was tendered to Dr. E. S. Moorhead, who was our principal champion, and to Dr. Alex Swan who was his chief aide.

During the years of Depression, and especially towards its end, Dr. Moorhead realized that the pre-war form of practice was unlikely to return. He studied and analysed the great mass of data which had been gathered, and the results of his analysis were found to be useful not only at home but also abroad. He next set himself to the task of investigating the new prepaid plans which were beginning to appear and, armed with a host of statistics, laid the foundation of what was to be-

come the Manitoba Medical Service. This was the first of its kind in Canada and one of the most satisfactory schemes in operation anywhere.

Being its parent, he was entrusted with its development and served as Medical Director till his retirement in 1948. Thus the plan now in operation owes a very great deal to Dr. Moorhead's vision and industry. It owes not a little, also, to the early Boards of Trustees who spent many hours on many evenings for many months as the plan took shape.

In the new building is a bronze tablet whereon are listed the names of those officers and trustees who were in office when the building was erected. There should also be another to similarly commemorate those who laid the foundations, and made real a dream. The first trustees should not be forgotten and certainly Dr. Moorhead's memory should be tangibly assured, for had it not been for him and his early associates the Service would not have come when it did.

It is to be hoped that those in a position to do so will remedy this defect. Those who bore the burden and heat of the day, who faced opposition and surmounted difficulties both foreseen and unforeseen, who gave a dream reality and made a vision tangible, the men who did these things deserve to be remembered. Already, to many, the crucial role they played is forgotten or unknown. Do not let it be said that we are neglectful of those to whom we all owe so much, or that we are too ungrateful or too niggardly to erect a permanent evidence of our appreciation.

Haustus Hemidesmi

I am led to understand that I have offended some of the gentlemen who visit us as representatives of the manufacturing chemists. Perhaps "offended" is too strong a word; annoyed or distressed might be a more proper one. Yet I can see no reason why any such feeling should be entertained. I merely mentioned (in an editorial written some months ago) how beholden we were to them and their employers, and this, I am sure, nobody can deny.

Everyone knows that, today, phenobarb is almost as necessary as the vitamins. Without it life would be scarcely tolerable to thousands upon thousands. But every one knows about phenobarb and half the magic of a remedy goes out of it when the patient knows what he is getting. Moreover patients tend to lose confidence in a doctor who supplies every member of a family with the same little white tablets. But when each one has his or her own remedy, distinctive in shape and colour, with no hint of barbital, improvement is marked and speedy. The manufacturing chemists have made this possible and is not that something for which we should be grateful?

And I make bold to say that if the use of the newest remedies had to wait upon the reading of original scientific papers, many of us would be years behind—might still, indeed, be writing prescriptions out of the B.P. which is a terribly out-of-date practice! Actually we owe a sizeable debt to the chemists who fashion these good new things (at the expense of the pharmaceutical houses) and to the writers who give us, in a simple and readable form, the gist of lengthy technical papers. Much of the direct-by-mail advertising matter finds its way more or less quickly into the waste paper basket but enough is retained, for present and future use, to guide the prescriber.

Medicine has changed enormously during the past few decades. Almost entirely we have become iatrochemists. Almost without exception our remedies are chemicals. Not the simple, old-fashioned chemicals but complex substances created by man and non-existent in any natural state. They are formulated in geometrical patterns, and their proper names are past remembering. Even their "pet names" are confusing and can be held in mind only when repeated often.

But the changes are not only in the remedies. The every-day ailments have also changed. What once was common has become rare. What we seldom heard about has become commonplace. Some invaders are barred by inoculations. Others are destroyed swiftly before they have gained a foot-hold. And Death, who will not be denied, finds new servants to baffle and defeat us.

One wonders if Nature has not in some way become offended. Perhaps in her beneficence she extends her care to germs which the microscope can reveal. These we have for years been slaughtering at will. Yet, like wraiths, there have emerged from their tiny corpses a host of infinitesimally small spirits which we call viruses and these, like avenging angels, go throughout the length and breadth of the land sickening and slaying almost without let or hindrance. Is it merely a coincidence that the increase in virus infections began, or at least became obvious, just after the introduction of our "wonder drugs?" Or can it be that these so potent remedies are two-edged swords, slaying our bacterial enemies with one edge while, with the other, they lay us open to attack by pernicious particles that can escape through filters and can hide from the microscopist?

This is wandering from the point. Before I know it some representatives of the manufacturers will complain that I am blaming their employers for this state of things. But of course I'm not. Indeed, in their laboratories, which are our munitions factories, clever men are pitting their wits against the ingenuity of Nature. The anti-virus weapons with which we shall ultimately be fur-

nished are likely to come from manufacturing houses and it is likely that we shall learn a good deal about them from the literature and lips of the detail men.

We should not resent their visits. Visiting us is their job and, I imagine, there are times when it is tedious and unpleasant. Quite often they know a great deal more about the actions of, and indications for, their merchandise than the doctors to whom they speak. Yet this they dare not openly proclaim. They must be tactful. They point out. They suggest. They respectfully draw attention to this or that. If the doctor is busy they must wait. If the doctor's ulcer is bothering him, if the day has been trying, the detail man becomes a convenient whipping boy, one upon whom the doctoral spleen can be safely vented. When I see two of these gentlemen in huddled conference I know what they are up to—they are swapping barbiturates and analgesics.

In fact they could very well advertise their products in quite another way. They could say: "Doctor, do I not look calm, comfortable and collected?" "Yes." Then the representative would relate the harrowing details of his day's work and tell how much of which of his samples he took to keep him going.

What has this to do with *Haustus Hemidesmi?* Practically nothing. *Hemidesmus Indicus* (Natural Order, *Asclepiadaceae*) is Indian Sarsaparilla. It was also known as *Smilax Aspera* and there was a time when it had a great vogue. Sir Lauder Brunton spoke of the *haustus* in glowing terms (though really he gave chief credit to the potassium iodide it contained). But that was long ago, in the days when the B.P. was in use, when doctors wrote real prescriptions, when synthetic chemicals were scarcely thought of and detail men were yet to be born.

How have the mighty fallen! Theriac, once worth more than its weight in gold has degenerated to treacle. A remedy which once owed its favour to the virtues of coca leaves and kola nuts, is now a "soda drink," and sarsaparilla has fallen even further for not even the soda fountains now bother with it.

Yet is it not a fact that "that which was is that which shall be?" And even at this moment, for aught I know, some curious chemist may be searching for smilaxian virtues, and will ultimately find some therapeutic marvel. To this he will give a name of learned length and thundering sound and then abbreviate it into a handy word which we shall learn from the advertising literature and hear spoken to us by the pleasant gentlemen who contribute not a little to our post-graduate instruction.

Scientific Papers for Annual Meeting

Final Notice

Our next number will appear on September 1st. By that time every plan for the convention must be laid. There will be no later opportunity to ask for contributions to the programme. We therefore urge upon all those who mean to address the meetings to so inform the Programme Committee. The information should properly be in their hands now, and if it be delayed they will be greatly handicapped. At least a tentative, and preferably the complete programme must be in our hands by August first if it is to be sure of appearing in the August-September number. Please bear this in mind.

Manitoba's Medical Men

VIII. Specialists

The Executive of the Manitoba Medical Association was requested by the board of the Manitoba Medical Service to define specialist status. This problem was not easily solved because of the fact that in addition to several specialist registers, the manual of the Manitoba Medical Service had Section 4 on page H-18 which gave these two bodies power to decide on specialist status. In order to clarify the situation a Manitoba Medical Service specialist status meeting was called. At this meeting the above mentioned section was deleted from the manual and the following resolution was passed:

"That this joint group recommends that the applicants for specialist status in Manitoba Medical Service be so recognized if their names appear on the specialist register of the College of Physicians and Surgeons of Manitoba."

The effect of this resolution was to have one body decide on specialist status instead of several. The College of Physicians and Surgeons would appoint a committee to deal with specialist status composed of representatives from the College of Physicians and Surgeons, the Manitoba Medical Association and the Faculty of Medicine.

The last clause in the by-law of the specialist register reads as follows:

"On and after the 1st day of January, 1954, either a fellowship of the Royal College of Physicians and Surgeons of Canada, or an enrollment therein as a certificated specialist shall be the accepted standard for registration as a specialist, provided, however, in special circumstances a person whose name appears in the Manitoba Medical Register, and who is not a Fellow or a certified specialist of the Royal College of Physicians and Surgeons of Canada, may apply to have his name

entered in the Specialists Register. The Council, after inquiry into the circumstances of the case, may in its sole discretion accept or reject such application, and if accepted, direct that upon payment of the prescribed fee, the name of the applicant be entered in the Specialists Register."

For various reasons, many specialists have not registered as yet. Some object to the fee as a matter of principle. The purpose of the fee is to defray the expenses of this register which is only of benefit to this one group of doctors.

Specialization in medicine began over one hundred years ago, when it was recognized that a man could do better work if he restricted himself to a particular field. As medical practice became more and more complex, the list of specialties increased in number, until today there are about twenty-two recognized specialties.

In order to get the best teaching possible in Medical Schools, University Boards have drawn heavily on the specialty groups. Most of the teaching is done by specialists, and contrary to public opinion, they do this teaching without salary or in some cases for a very small honorarium. Not only do they constantly instruct students in the Medical College, but they also instruct internes and nurses in the hospitals. Their work of teaching does not stop with these groups because throughout the years they constantly help and instruct men in general practice in procedures that have taken them many years to learn, and have cost them large sums of money. The result of having an excellent Medical School, combined with having superbly trained specialists in the school and in the hospitals, has elevated the general standard of medical practice in the province to such a degree, that no longer do the citizens have to go elsewhere for brain surgery, thoracic surgery—both lung and heart, plastic surgery, and fenestration operations of the ear, and many other difficult and intricate operations. The same can be said in the field of internal medicine and about the other non-surgical specialty groups.

It is reassuring to know that governmental bodies are aware of these factors, inasmuch as preparations are now underway to enlarge the Medical School to give added opportunities, not only to the Medical students, but also to the teaching staff, who require added facilities for teaching and research.

Within the last few years, a large number of highly trained men in various specialties of medical practice, have come from Europe and the United States to Manitoba, bringing with them new ideas that are certain to bring enormous benefits to the people of Manitoba.

L. A. Sigurdson, M.D.

Letter to the Editor

To the Editor,
The Manitoba Medical Review,
Winnipeg, Man.

Dear Dr. Hossack:

Having now passed my three score years and ten, I may be rightly classified as one of the "also rans." I can now settle down in my own house (as yet not fully paid for), in my arm chair, by my fire place, with my two tabby cats and look out on my garden while quaffing slowly, a Scotch and Soda (certainly not a diluted Coca-Cola), and watch the world and my highly respected professional colleagues move forward. I can read your thoughts: "Poor, old Strong! At last his rather questionable past has caught up with him. The choice seed that he sowed in his early days has germinated and flourished into hardening of the arteries, vascular cerebral spasm and many other pathologies." (The younger Meds will understand and describe these much more clearly than I am able to do). Now why all this? Principally that before I fly upwards to sit beside my Maker (His right side, of course, and actuarially speaking, I should have departed and taken my seat there three years ago). Before, as I say, I thus depart, I would like to leave a few of my thoughts, philosophical or constructively critical, for my colleagues and friends to chew their respective cuds on as they too climb the weary ladder towards eternity.

Today I would deal with the Anaesthetists, but only in part, for after all their duties are inseparably bound up with those of the surgeon, hospital and patient. These "anaesthetising" ladies and gentlemen, and I mean ladies and gentlemen in every sense of the word, have been up to the present, overworked and underpaid, although most proficient and always taking it with a smile. These professionals have now by united effort at last commenced to assert themselves and demand their rights. But I am afraid that in obtaining this recognition of their reasonably fair claims they are following methods that are hurtful to themselves, to the surgeons and definitely to the patient.

Themselves. The public have become aroused by, and are greatly antagonistic toward, this additional medical cost. Along with the increased rates of the Blue Cross it has come to them as a bolt from the blue. (No pun is intended). This resentment has made them definitely antagonistic toward the anaesthetists themselves.

The Surgeon. He is probably also handicapped by this new time-monetary institution. If he has

a conscience at all, and most surgeons have, he is bound to consider the economy of his patient and is probably operating with one eye on the exposed belly and the other on the clock. The competent surgeon is probably working at a little increased speed or (and this is far more important), leaving certain minor things undone that should be corrected before abdominal closure. The younger, less experienced, doctor who is probably dealing with patients not quite as financially strong as the above class, is even more handicapped, opening and closing the abdomen too rapidly, packing bleeding patients with gauze or oxicel instead of ligating the vessels, and several other sloppy points in their technique, not mentioned.

The Patient. Besides being exposed to the surgical defects as noted above, which the time feature in the operating room brings on, he also has to bear an additional cost. This is proportionately very great to the average young man who is bringing along a wife and three kids and probably trying to pay off the balance of the Mortgage on his cottage.

Now, how can this criticism be constructive and corrective?

1. **The Anaesthetists.** Besides being exposed to the surgical defects as noted above, which the time feature in the operating room brings on, he also has to bear an additional cost. This is proportionately very great to the average young man who is bringing along a wife and three kids and probably trying to pay off the balance of the Mortgage on his cottage.

2. **The Surgeon.** The surgeon surely could reduce his fees from 10 to 15% and still be reasonably paid for his services under our present schedule.

3. **The Patients.** They should be advised before entering the hospital of the advantages and disadvantages of the Blue Cross. They should be told about the hospital extras they are expected to pay, also the additional fee for anaesthesia. They should be told of the tremendous advantages of our different prepaid medical plans and that the doctors under these plans are working for a lower professional fee than they were accepting in 1920, and that, as private patients, our charges would be much higher than those paid to us by the M.M.S. After all, by far the best-selling agent we have for our prepaid medical plans is the family physician.

4. **The Blue Cross.** This does not come under the scope of this letter, but it might be pointed out to the Board and the Hospitals that piece work is far more in the interest of the patient than time service, for the operating room and its staff for all minor and major operations.

And now my dear Hossack, all this is respectfully submitted.

Sincerely,
Con Strong.

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Manitoba Medical Service

Address of Dr. P. H. McNulty

Retiring Chairman, before the Board of Trustees at
the Annual Meeting of the Manitoba Medical
Service, March 16th, 1954



Members of the Board of Trustees:

At this point in our Annual Meeting it is customary to review some activities of the year that has gone. Almost invariably this is done by a recital of figures which, though impressive in themselves do not bring to life the humanitarian services behind them and inseparable from them. Before we go on to speak of some aspects of the M.M.S. activities which are not covered in the financial report just submitted to you by the Honorary Treasurer, we do well to pause for a moment and ask ourselves again what M.M.S. is and ought to do.

M.M.S. is in one sense a bursar or a dispenser of dollars to physicians from and on behalf of subscribers. The M.M.S. cannot create money: it can only channel a pre-determined amount to doctors in exchange for an indeterminable cost of services rendered. While it is true that the demand for prepayment care is universal, we have to be sure that the need is genuine in all cases.

I am bold enough to assert that the seven features of M.M.S. establish it in a unique place in the medico-economic picture of this Continent. We have no age limit on group subscribers, no dollar limit on diagnosis, no dollar limit on cost of care, no extra billing by specialist or general practitioner, no extra charge for dependent care, no cancellation of contract on retirement, no dollar problem between patient and doctor.

We do well not to be complacent about this. The status quo is incompatible with life in any organism. The organism that does not change under stimulus is dead. No doubt changes will come, and M.M.S. must be sensitive enough to pick up these stimuli from the general public and medical profession, from which groups are derived this Board of Trustees.

For the moment, let us see what has been accomplished for our people. In 1953 we paid for 652,102 services, an increase of 137,594 over 1952. That is a remarkable jump. Surgical operations added up to 24,930. Hospital calls made were 55,456. Office calls were rendered to the figure of 292,007. Home calls made, 88,517. Obstetric cases confined, 3,419. Laboratory, E.C.G. and B.M.R. tests came to 68,709. X-Ray Services completed, 39,237. Refractions or eye testing were 10,974. Injections 32,207. Medical treatments, 29,781. Consultations, 3,850. Anaesthesia, 3,005.

Please note that since January 1, 1954, the cost of anaesthesiology in hospitals has been taken over by M.M.S. without anything in the subscriber's premium for it; however, I am optimistic that 80% payment can still be forthcoming despite the jolting figures so far available for 1954's activities. Despite the deficit just reported by the Honorary Treasurer for 1953, I am incurably optimistic that at least 85% payment is possible for 1954 but—and notice this "but"—this all depends on several factors.

Let me digress for a moment to think aloud. We should from time to time re-examine our purposes and programmes. We are, as I think, organized to pay for services that are necessary, adequate and appropriate. It is salutary to look up these words in a good dictionary and assimilate all that they can mean. Necessary connotes "being indispensable to an end." Adequate suggests "that which is just, fair, nothing in excess, nothing wanting." Appropriate hints at "fitness, proper, suitability in a special way. With this trefoil test we are not likely to over-service. But these words of mine are not directed at you, fellow members, but directed to those for whom the cap will fit.

After this brain washing, we shall find ourselves more selective in our choices of means and methods and incidentally helping to keep high the prorating figure every month. By doing this, we are acting as faithful partners with our colleagues in this venture. There is sometimes a misconception on the part of many people about M.M.S. It is our conception that M.M.S. coverage is a lifeline—I repeat—a lifeline thrown out to subscribers and medical members, but too often it is regarded by many as a pipeline—through which is fed everything that human nature can regard as service. Let's watch these lines.

Coming back from this digression, it is my view that physician-hungry patients and dollar-

hungry doctors must undergo a conversion of head and also of heart. If this is not forthcoming the costs of care will rocket to such a point that the bell will toll—and that will be the end for all of us. State Medicine will take over, a disaster to the subscribers and medical members. Please remember, you who are non-medical trustees of the Board and you too, our medical representatives on the Board. This is our last stand; make it stick or both the honour of the patient and the freedom of free choice of doctor, and the freedom of free choice of patient will be gone. Both lifelines and pipelines will be closed. Therefore, we must be vigilant that our splendid programme of medical care is not killed by avarice or the "gimme" complex.

There are other problems and it is interesting to notice how other people have handled them or propose to handle them. On medical indigent care for example, 5 provinces of Canada, viz., British Columbia, Alberta, Saskatchewan, Ontario and Nova Scotia have organized medical care for indigents with an expenditure during 1952 of $3\frac{1}{2}$ million dollars for this very deserving group of people.

In the U.S.A. for the past few months before a Committee of Congress there have been several hearings of experts in medical economics and I will just note some of the suggestions in passing. For the jobless, it has been suggested that prepaid medical care protection ought to be part of unemployment compensation. Another suggestion would provide medical coverage during unemployment by prepaying an additional amount with each monthly premium while employed, thus leaving so many units of credit for the jobless period. Before Congress, it was suggested that premiums for the medical indigent should be derived from welfare agencies. At these sessions there were other remedies submitted to aid or support the non-profit plans in aiming at solvency. One of these devices mentioned was Co-insurance of risk by the premium payer. This is a concept with which we are familiar in types of insurance like automobile coverage. Another concept, not exactly new but widely adopted for study because it was proposed by President Eisenhower in his recent proposals for better health care, was Re-insurance of risks. This would entail a payment

from the non-profit plan to a Federal Corporation which would assume the costs of a risk over and above an agreed amount for each liability. By re-insurance, it was hoped that non-profit plans would experiment towards providing comprehensive medical care within reach of the average and low-income subscriber. It was observed in the hearings that only 15% of the total medical bill of American families is now being paid by all the insurance plans put together. With this alarming thought we can return to Manitoba and congratulate ourselves on having done so much for our people though we do not yet have all the answers to the problems of our people. Much of our success in M.M.S. during 1953, in terms of service to subscribers and doctors, must be attributed to the amenities and efficiency derived from our new building and the enhanced morale of our administrative staff. You may recall that at this time last year we were on the eve of taking possession of our new building, after many months of flitting around the city for space. All can be congratulated on the outcome of our planning. There are still jobs to be completed or perfected on the building but we shall hand over a "check list" to the incoming chairman within the next few days.

All in all, we have had a good year working closely as a team in the interests of the public and profession. However, this evening brings the parting of the ways for some of us. All of us leaving the Board do so, I am sure, with genuine reluctance. To you, about to go with me out into the wilderness, may I say "well done gentlemen." To you who take over, may I express my wish for your very great success. May the interests of the average man and average doctor be your prime concern at all times. May you receive the prompt and generous support accorded me since my first position as Treasurer. May you savour the joy of accomplishment as I have. May you long enjoy the affection and esteem that I appear to have won from the administration and employees. As I lay down my commission in my last official act, I wish to say how grateful I am for your confidence in me over the years. It has been good to go along the road together. My last word to you is not farewell, but au revoir. I trust that one day this group will once again go along together as in the past, in a true fellowship of service.

Social News

Reported by K. Borthwick-Leslie, M.D.

It is cheering to read and hear about the "all out" evidence of love and appreciation of Transcona citizens towards their life long friends, Dr. and Mrs. Murdoch McKay. The Doctor's birthday, 70th, was the excuse for the day long royally organized oportunity for the town to pay homage to the man who for thirty-four years had looked after them so faithfully and well.

Surgeons make the headlines once more. Honorary Degree of Doctor of Law will be conferred on Dr. Charles W. Burns at the U. of M. annual convocation.

Dr. S. S. Peikoff was awarded a Peruvian Fellowship and the Brazilian Academy of Science Fellowship. Sammy was the official Canadian delegate to the American College of Surgeons International Congress in Sao Paulo, Brazil. Congratulations to both, and also to Drs. T. W. Fyles and J. P. Maclean, of the General Hospital Staff, who have been awarded fellowships from the R. Samuel McLaughlin Foundation. Dr. Fyles will

study at Research centres in London, Edinburgh and Scandinavia. Dr. Maclean, in New York at Sloan Kettering Institute, on cancer research.

Dr. and Mrs. H. P. Kitchen, apparently on pleasure bent only, are now thoroughly enjoying an extended tour of the United Kingdom and Europe.

Westminster United Church was the scene, May 1, of the wedding of Mary Schoeffer and Dr. Stuart L. Carey.

Dr. and Mrs. Carey will reside at The Pas, where the doctor is medical superintendent of Clearwater Lake Sanatorium.

Dr. and Mrs. W. H. Ostapovitch, Holland, Man., announce the arrival of Penny Jean, May 11.

Dr. and Mrs. K. R. Crawley, Steinbach, Man., proudly announce the birth of their son, Blair Delbert, May 10th.

P.S.—It's a tough racket, when to compete for headlines, Mac, you have to have robberies, shootings, etc. Exciting by Jove.

Nothing is Sacred on East Five W.G.H.

By Susan Wilder
New Westminster, B.C.

The very best wishes for a speedy, comfortable convalescence to Dr. Dorothy Hollenberg, also "thanks" Dorothy for your thoughtful contribution to the column. The authoress of the following choice bit of rhyme, is Susan Wilder, New Westminster, B.C., whom Dr. Dorothy refers to as "the kid sister":

Are you getting rather caustic
Re procedures diagnostic,
Do you feel they're playing havoc
With your Id?
Just relax, my elder sibling,
When your sphincter won't stop dribbling,
And remember, you are now the Barium Kid.

When your state of being is healthy,
Be you rich, or poor, or wealthy,
Your peristaltic pattern is your own.
You evacuate at leisure,
Though the process is no pleasure
You confine it to the privy of your home.

Is it hard to stay real perky
When your gastric tract is murky
With Barium and diagnostic stuff?
When the Roentgen rays start humming
And your Haustral marks are running,
Do you cry, "Lay off, Lay off—that is enough?"

Good philosophies of living
Include getting, and then giving,
So you give your all to diagnostic aids.
Does it help your alter ego
My erudite amigo,
To know the meaning of these enemical raids?
Does it help, at all my sister,
That you know your Boyd and Lister,
Your Thorek, Grollman, Tiday, and too, Brown?
When you're of medical profession
Does it help this rank transgression
And help you keep the insidious barium down?
Though my talents are quite frothy,
And my cerebra probably mothy,
I have some sage advice to give to you.
It's about the rib resection
That's a matter of selection,
When the day of operation will be due.
Should resection be elective,
Make sure they're damn selective,
As to where your rib will end its bony state.
Don't, like Adam, trust your Surgeon,
Remember, he was virgin,
He had no other way to find himself a mate.
I think two sexes are abundant,
More would only be redundant,
Cause confusion, chaos and our ethnic ruin.
So, for the sake of all posterity
Hold your ground without temerity.

Come home, Dody, come on home real soon.



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Kountz, W. B.: Ann. Int. Med. 35:1055, 1951.

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Winnipeg Medical Society

Reported by R. H. McFarlane

A special meeting of the Society was held at the Medical College on April 13th, this being the week of the annual refresher course put on by the Medical College. The speaker, Dr. F. S. Brien, Professor of Medicine, University of Western Ontario, was introduced by Dr. J. M. Kilgour, who had served with Dr. Brien overseas during the war.

Dr. Brien's paper was entitled "Medical Emergencies." First he spoke of the diagnosis and treatment of certain neurological emergencies, such as acute spinal epidural abscess, extra-dural hemorrhage (arterial), subdural hematoma, status epilepticus and suppurative meningitis. In the first three named, the main point was the necessity for early and accurate diagnosis so that appropriate surgical interference could be undertaken without loss of time. In the case of meningitis, he emphasized the need for accurate bacteriological diagnosis, but felt that such patients, once the spinal fluid had been sent for culture, should be treated with penicillin as the antibiotic most likely to be effective. He also pointed out that the use of intrathecal penicillin is infrequently, if ever, indicated. For status epilepticus, the intravenous use of sodium luminal, up to gr. v-x or more along with the use of pentothal, was recommended. He mentioned that in some extreme instances, complete anaesthesia might be needed.

The next main topic was the use of nor-adrenalin for shock occurring without oliguria; occurring from such causes as surgery, pancreatitis and so on. This adrenalin-like substance produces peripheral vasoconstriction, arterioles and even venules being affected. It is given as a continuous I.V. drip in solution of 5% glucose and water containing 4 mgm. of nor-adrenalin to the litre. Usually 20-40 drops per minute would suffice to keep the systolic pressure above 100 mm. Hg. but the rate is controlled to match the pressor response as determined by frequent blood pressure readings.

Following this, mention was made of the use of a Veriloid drip, containing 4 mgm. of Veriloid to a litre of 5% glucose and water for hypertensive crises. Other subjects dealt with included Peripheral Arterial Occlusions, Acute Dilatation of the Stomach, Hematemesis, Barbiturate Poisoning and Addisonian Crises. Two methods for the treatment of Barbiturate intoxication were noted: (1) Continuous subliminal electro-shock therapy. (2) Allowing the patient to sleep it off with only such aids as tracheotomy to provide an adequate airway, nor-adrenalin for shock and coramine. PicROTOXIN is apparently no longer considered of value. One point in the treatment of shock in Addisonian

crises seemed important, i.e. the use of intravenous cortisone. The cortisone is dissolved in 95% alcohol and this solution is missible with normal saline, though without the alcohol, the cortisone is insoluble.

Dr. Brien covered a considerable number of unrelated entities in this paper, and, presumably for lack of time, left out altogether such other emergencies as Coronary Occlusion, Atelectasis, and so on. His remarks were interesting and pertinent.

At a recent meeting of the Society's Executive, it was announced that physicians wishing to enroll as new members of the M.H.S.A. with the Winnipeg Medical Society Group could do so each month. Previously, a new member could join the group only at special opening dates occurring twice yearly. Thus, anyone wishing this service may have his application acted upon in the month of its submission.

The regular meeting of the Society was held on April 23rd at the Medical College. The first item was a consideration of "Poliomyelitis" by Doctors J. D. Adamson, Roper Cadham and Morley Elliott. Dr. Adamson spoke of the necessity for preparedness for another polio epidemic and mentioned some of the factors that would be of importance such as provision of respirators and experienced medical and nursing personnel. It was his opinion that the summer of 1954 might well be a year relatively free from this disease as there must, after the large epidemics of the past two years, be a minimal number of susceptibles left in the population.

Dr. Cadham, speaking for the City Health Department, gave some figures regarding the effectiveness of passive immunization with gamma-globulin as it was used here in 1953. Of 1,403 contacts of paralytic polio thus immunized, 13 developed polio (3 paralytic): a rate of 9.2 per 100,000. Of 502 contacts of paralytic polio not so immunized, 13 developed polio (10 paralytic): a rate of 28 per 100,000. It thus seemed that some degree of protection had been afforded, although this is at variance apparently with experience in the United States.

Dr. Elliott, speaking for the Provincial Department of Health, stated that by July, 1954, there would be available 60,000 vials of gamma globulin, with a further production of 8,000 vials a month thereafter; this to be distributed for the Provincial Health Departments on a population basis. No charge will be made for this product when administered to eligible persons. The Manitoba Advisory



among the
candidates
for
COMBANDRIN*

PROTEIN ANABOLIC STEROID HORMONE COMBINATION

...tired
elderly
patients

With Combandrin, the tired, elderly patient lacking the metabolic support supplied in earlier years by gonadal hormones can often be made stronger, more alert. Formation and retention of protein are promoted, aging bone can be given a "new lease" on life, and mental and emotional reactions may be favorably influenced. More persons can "live"—not merely exist—in their sixties, seventies and eighties. For, the overall results of Combandrin therapy (balanced androgen-estrogen steroid therapy) in the aged "is a lessening of the degenerative state . . ."

Kountz, W. B.: Ann. Int. Med. 35:1055, 1951.

SUPPLIED: INTRAMUSCULAR 1 cc. ampules and 10 cc. vials. Each cc. contains: estradiol benzoate, U.S.P., 1 mg. and testosterone propionate, U.S.P., 20 mg., in sesame oil.

TRANSMUCOSAL TABLETS in packages of 10, 25 and 100 tablets. Each tablet contains estradiol, U.S.P., 1 mg. and testosterone, U.S.P., 10 mg., in special base.



World's Largest Producer of Antibiotics

PRESENTS THE FINEST IN VITAMINS AND HORMONES

VITAMIN-MINERAL FORMULATIONS

PFIZER SYNTEX HORMONES

PFIZER CANADA
Division of Pfizer Corporation
8311 Royden Road
Montreal 9, P.Q.

*TRADEMARK

Winnipeg Medical Society

Reported by R. H. McFarlane

A special meeting of the Society was held at the Medical College on April 13th, this being the week of the annual refresher course put on by the Medical College. The speaker, Dr. F. S. Brien, Professor of Medicine, University of Western Ontario, was introduced by Dr. J. M. Kilgour, who had served with Dr. Brien overseas during the war.

Dr. Brien's paper was entitled "Medical Emergencies." First he spoke of the diagnosis and treatment of certain neurological emergencies, such as acute spinal epidural abscess, extra-dural hemorrhage (arterial), subdural hematoma, status epilepticus and suppurative meningitis. In the first three named, the main point was the necessity for early and accurate diagnosis so that appropriate surgical interference could be undertaken without loss of time. In the case of meningitis, he emphasized the need for accurate bacteriological diagnosis, but felt that such patients, once the spinal fluid had been sent for culture, should be treated with penicillin as the antibiotic most likely to be effective. He also pointed out that the use of intrathecal penicillin is infrequently, if ever, indicated. For status epilepticus, the intravenous use of sodium luminal, up to gr. v-x or more along with the use of pentothal, was recommended. He mentioned that in some extreme instances, complete anaesthesia might be needed.

The next main topic was the use of nor-adrenalin for shock occurring without oliguria; occurring from such causes as surgery, pancreatitis and so on. This adrenalin-like substance produces peripheral vasoconstriction, arterioles and even venules being affected. It is given as a continuous I.V. drip in solution of 5% glucose and water containing 4 mgm. of nor-adrenalin to the litre. Usually 20-40 drops per minute would suffice to keep the systolic pressure above 100 mm. Hg. but the rate is controlled to match the pressor response as determined by frequent blood pressure readings.

Following this, mention was made of the use of a Veriloid drip, containing 4 mgm. of Veriloid to a litre of 5% glucose and water for hypertensive crises. Other subjects dealt with included Peripheral Arterial Occlusions, Acute Dilatation of the Stomach, Hematemesis, Barbiturate Poisoning and Addisonian Crises. Two methods for the treatment of Barbiturate intoxication were noted: (1) Continuous subliminal electro-shock therapy. (2) Allowing the patient to sleep it off with only such aids as tracheotomy to provide an adequate airway, nor-adrenalin for shock and coramine. PicROTOXIN is apparently no longer considered of value. One point in the treatment of shock in Addisonian

crises seemed important, i.e. the use of intravenous cortisone. The cortisone is dissolved in 95% alcohol and this solution is missible with normal saline, though without the alcohol, the cortisone is insoluble.

Dr. Brien covered a considerable number of unrelated entities in this paper, and, presumably for lack of time, left out altogether such other emergencies as Coronary Occlusion, Atelectasis, and so on. His remarks were interesting and pertinent.

At a recent meeting of the Society's Executive, it was announced that physicians wishing to enroll as new members of the M.H.S.A. with the Winnipeg Medical Society Group could do so each month. Previously, a new member could join the group only at special opening dates occurring twice yearly. Thus, anyone wishing this service may have his application acted upon in the month of its submission.

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Committee recommends:

(1) Age limit for use, 6 months to 50 years (instead of 30).

(2) In a serious epidemic, widespread general immunization of as many as possible.

(3) Use in all confirmed contacts regardless of whether contact cases are paralytic or not.

(4) Use in certain selected groups of individuals, whether contacts or not, e.g. pregnant females.

(5) Supply to be made available through private physicians.

The main speaker of the evening was Dr. C. W. Burns, President of the Canadian Medical Association. Dr. Burns' topic was "Problems of the Canadian Medical Association and Health Insurance Outlook." He was able to set forth something of the workings of the C.M.A. and some of the problems it has had to consider.

The first main subject was concerned with the organization of the C.M.A. and the great diversity of administrative problems with which it had to deal, consisting as it does of a President, a Chairman of Council, a Secretary General and his Deputy, an Executive and a General Council of 120 members and a general membership of 10,000. The Executive has the power to act for the General Council apart from its meetings, which ordinarily occur only once a year at the Association's Annual Meeting. The financial scope of the Association was clearly indicated by the statement that its assets as of December 31st, 1953, totalled approximately \$443,000, and that its 1954 income would be approximately \$348,200 as against planned expenditures of \$336,280 for the same period. The main sources of revenue were from membership fees, bond interest and profits from the Journal.

One of the besetting problems is the question of whether the Association should own its own building for headquarters, and if so where it should be situated. As the matter now rests, it seems Toronto or Ottawa will be the likely site.

Dr. Burns then turned to the rather general problem of "Rehabilitation." His concern, and that of the C.M.A. is with the lack of public and medical interest in this phase of our society. He pointed to the ageing of the population, and the members suffering from chronic illnesses such as arthritis, cardiac disabilities, etc., as particular reasons for the need to maintain and encourage economic productivity in these members of the community. He emphasized both the humanitarian and economic benefits to be reaped from an adequate rehabilitation programme.

Another subject mentioned was the formation of a College of General Practice. It was noted that the C.M.A. would put up \$10,000 to assist in the organization of the College; not as a loan, but yet with some expectation of the money being later repaid.

The final subject which Dr. Burns spoke of was the ever-pressing problem of how best can adequate medical care be provided for the whole population. It is not possible in this brief review to go into all that was said. However, he did reiterate the policy stated by the C.M.A. in 1949, "that it would not be opposed to a plan that would be beneficial to the people of Canada and provide them with a free choice of doctors." He did emphasize and recommend the use of voluntary prepayment plans, wherein the individual meets his own responsibility for himself and his family. Further it was suggested that some means might be found for payment of premiums for those not able to afford such insurance. The important fact however, Dr. Burns emphasized, was not the readiness or un-readiness of a particular plan at this particular moment, but that the Executive of the C.M.A. had this problem constantly under study in the light of expanding experience with pre-paid medical care plans.

He ventured to predict that no form of Government or voluntary Health Insurance will survive unless it is established on a contributory or partnership basis. Whether it be sponsored by employer or government matters not. To be successful and to minimize abuses, the insured must be a partner and a contributor either to a complete coverage plan or to a plan with restricted benefits. A deductible portion, or one with a generous ceiling for both medical and ancillary services could have the same stabilizing effect.

In support of this viewpoint, Dr. Burns referred to the experience of the Swift Current Health Region which since its inception had always carried an alarming deficit. On January 1st, 1953, it became necessary to impose a utilization fee on home calls. This resulted in more than a 50% reduction in the number of house calls. On August 10th, 1953, a similar restriction went into effect in connection with office visits the Board being responsible for only a portion of the fee. As a result of these restrictions the Regional Board had for the first time in its history a surplus of approximately \$75,000 in this comparatively small enterprise. These restrictions did not impose a hardship on those who were unable to pay for medical attention for the Board continued as formerly to provide out-patient services at all hospitals for all residents free of any extra charge.

The experiment suggests abuses of a system which provides an unrestricted overall coverage for all citizens. The abuses were no doubt not all due to the patients. We of the medical profession must be prepared to accept our share of misuse of the privileges intended and budgeted in any pre-paid health insurance plan. No matter by whom or under what auspices it is sponsored. We are or should be in favor of any plan which is provided for the better medical care and health

of the people of Canada but no plan can survive and be subject to unfair and unnecessary abuses, no matter from what source they come.

Your officers of the Canadian Medical Associa-

tion must continue to be alert and be prepared to oppose if need be, any National Health Insurance plan which is not acceptable to the medical profession of Canada.

Committee Reports 1953-1954

Report of the Secretary

To the President and Members of
The Winnipeg Medical Society:

Your Secretary submits the following report of the year's activities.

MEETINGS:

The Society met seven times regularly during the period 1953-4. The annual Hospital meeting attracted over 200 doctors at St. Boniface in January. At the annual special session with the University Post Graduate Course Dr. F. S. Brien of the University of Western Ontario was the Guest Speaker. Our other visiting, and distinguished, speaker, Prof. Illingworth of Glasgow, addressed the regular September meeting. Attendance at regular meetings averaged 111.

IN MEMORIAM:

The Society observes with regret the deaths of four members: Dr. W. E. R. Coad, Dr. John M. McEachern, Dr. R. A. Claassen and Dr. F. R. Chown.

CIVIL DEFENCE AND THE WORLD WAR II MEMORIAL:

These projects are receiving the Society's earnest attention, though progress has been slow.

Respectfully submitted.

Earl Stephenson,
Secretary.

Treasurer

To the President and Members of
The Winnipeg Medical Society:

Herewith certified financial statement from our auditors, Messrs. Thornton, Milne and Campbell:

All of which is respectfully submitted.

D. Parkinson,
Treasurer.

* * *

5th May, 1954.

To the President and Members,
The Winnipeg Medical Society,
Winnipeg, Manitoba.

Dear Sirs:

We have examined the accounts of the Society for the year ended 30th April, 1954, and submit herewith our report thereon together with the following relative financial statements:

EXHIBITS:

"A" Statement of Revenue and Expenditure for the year ended 30th April, 1954.

"B" Balance Sheet as at 30th April, 1954.

Revenue and Expenditure

The operations for the year, as set forth in Exhibit "A" have resulted in an excess of revenue over expenditure of \$1,267.66. Membership fees received are in accordance with duplicate receipts examined by us but are not subject to further verification. Adequate vouchers have been examined in substantiation of all expenditures.

In accordance with the Minutes of the Council Meeting of 18th January, 1954, the sum of \$1,000.00 has been placed in the Special Library Fund for the use of the Library Committee of the Faculty of Medicine. A statement of the transactions affecting this account during the year is shown in Exhibit "A".

Balance Sheet

In our opinion the Balance Sheet submitted and marked Exhibit "B", is properly drawn up so as to exhibit a true and correct view of the state of the affairs of the Winnipeg Medical Society as at 30th April, 1954, according to the best of our

information, the explanations given to us, and as shown by the books of the Society. We have received all the information and explanations which we have required.

We obtained from The Bank of Toronto verification of the bank balances, subject to allowance for outstanding cheques as shown by the books.

The Society's investments as at 30th April, 1954, were as follows:

Fully Registered:	Market Value	
Par Value	Cost	Value
\$1,000.00 Govt. of Canada 3% 1957	\$1,000.00	\$1,002.00
4,000.00 Govt. of Canada 3% 1966	4,042.50	3,975.00
1,500.00 Govt. of Canada 3 1/4% 1978	1,473.75	1,593.75
\$6,500.00		\$6,516.25

These securities are held in a safety deposit box and were presented for our examination. All interest, on a received basis, has been accounted for on the books of the Society.

In so far as we have been able to ascertain all liabilities applicable to the year under review have been recorded on the books.

In conclusion, we wish to express our appreciation of the courtesies extended to us during the course of our audit.

Yours very truly,
THORNTON, MILNE & CAMPBELL,
Chartered Accountants.

Exhibit "A"

Statement of Revenue and Expenditure

For the year ended 30th April, 1954

General Funds

REVENUE

Annual Dues:	
Current Year—Active Members	\$3,410.00
Other Members	22.00
Prior Years	30.00
	\$3,462.00
Bond Interest	206.24
	\$3,668.24

EXPENDITURE

Audit Fees	\$ 25.00
Bank Charges	6.22
Catering	149.24
Donations	177.00
General Expense	82.03
Lantern Slides Expense	50.00
Manitoba Medical Association—	
Office Salaries	1,260.00
Printing, Stationery and Postage	430.09
Speakers — Honoraria	200.00
Telephone Expense	21.00
	2,400.58
Excess of Revenue over Expenditure	\$1,267.66

Library Fund

REVENUE

Appropriated from General Surplus	\$1,000.00
Bank Interest	14.87

EXPENDITURE

Books Purchased	\$ 252.38
Library Supervision	236.00
Maintenance, Binding, etc.	113.85
	602.23

Excess of Revenue over Expenditure	\$ 412.64
------------------------------------	-----------

Exhibit "B"

Balance Sheet as at 30th April, 1954

ASSETS

Cash:

On deposit with The Bank of Toronto \$1,900.03

Investments — at cost:

Government of Canada Bonds 6,516.25

\$8,416.28

Special Library Fund:

Cash:

On deposit with The Bank of Toronto 1,647.10

\$10,063.38

LIABILITIES

Membership Fees Paid in Advance \$ 20.00

Bond Interest Received in Advance 15.00

Surplus:

Balance as at 30th April, 1953 \$8,113.62

Add:

Excess of Revenue over Expenditure
as per Exhibit "A" 1,267.66

\$9,381.28

Less:

Appropriated for Library Fund 1,000.00

8,381.28

Special Reserve Library:

Unexpended Balance, 30th April, 1953 \$1,234.46

Add:

Excess of Revenue over Expenditure
as per Exhibit "A" 412.64

1,647.10

\$10,063.38

Report of Trustees

To the President and Members of
The Winnipeg Medical Society:As Senior Trustee, I wish to report the following securities
as being held in Safety Deposit Box, Bank of Toronto, 394
Portage Avenue:

Dominion of Canada Bond, 3%, 1957 \$1,000.00

Dominion of Canada Bond, 3%, 1966 1,000.00

Dominion of Canada Bond, 3%, 1966 1,000.00

Dominion of Canada Bond, 3%, 1966 1,000.00

Dominion of Canada Bond, 3%, 1966 500.00

Dominion of Canada Bond, 3%, 1966 500.00

Dominion of Canada Bond, 3 3/4%, 1978 1,000.00

Dominion of Canada Bond, 3 3/4%, 1978 500.00

\$6,500.00

Balance on Deposit, Bank of Toronto, as at
April 30, 1954 \$1,900.03The aforesaid Bonds and Bank Deposit have been vouched
for in the Auditor's Report.I have personally inspected the office equipment of the
Society at 604 Medical Arts Building, the equipment in the
Manitoba Medical College and the Lantern in care of Mr.
Gordon Axtell, and found them to be as listed herein:

Office Equipment at 604 Medical Arts Building:

1 Steel Filing Cabinet, 3 drawers; 1/3 Interest in Elliott
Addressing Machine; 1/3 Interest in Mimeograph Machine;
1/3 Interest in Underwood Typewriter, 14" Carriage, Serial
No. 5732553-14; 1/3 Interest in Burroughs Adding Machine;
1/3 Interest in "Copy-right" Holder.

Equipment in Manitoba Medical College:

2 Plaques—Honor Rolls of Past Presidents (in Theatre A
of the Medical College); 1 Gavel—This gavel was made
from wood from the ruins of the Royal College of Surgeons,
and was presented to the Winnipeg Medical Society by Dr.
John C. Hossack.

In Care of Mr. Gordon Axtell:

1 Delineascope Lantern, Model O.J.R., 3647, made by
Spencer Wells Co. of Buffalo, New York, and one spare
bulb for same.The following equipment previously listed in the custody of the
caretaker of the Medical College has either been disposed
or has depreciated so greatly that it is of little value:
12 Wooden Chairs; 4 Wooden Trestles and 2 Wooden Table
Tops for same; 32 Cups and Saucers; 1 Coffee Urn.As our catering service is now very adequate, the Council
of the Winnipeg Medical Society has agreed to donate these
last listed articles to the Medical College for their use and
disposal.

All of which is respectfully submitted.

A. R. Birt,
Senior Trustee

Membership Committee

To the President and Members of
The Winnipeg Medical Society:The total membership for 1953-54 season is 450, made up as
follows:

Active paid-up members	316
Active paid-up members, half rate	51
Associate paid-up members	8
Non-Resident paid-up members	4
Total Paid-up Membership	379
Life Members	24
Free Membership—65 Years and Over	26
Membership Fees Unpaid	21
Total Membership	450

Thirty-eight new members have been added to the total
during the year.Thirteen members have been lost to the Society during the
year, 4 by death and 9 have left the province.Total membership for 1952-53 was 422 as against 450 for
the current year, a gain of 28.Total paid-up membership for the current year is 379 as
against 368 for 1952-53, a gain of 11, and the number of
membership fees unpaid this year is 21 against 11 unpaid last
year.

Respectfully submitted.

Murray Campbell,
Chairman

Programme Committee

and

Post Graduate Committee

To the President and Members of
The Winnipeg Medical Society:The following is an outline of the programmes of the Society
for the past year:Eight regular meetings and one special meeting were held.
Titles and speakers were as follows:

September 10, 1953:

C. F. W. Illingworth, C.B.E., F.R.C.S., Edin., F.R.F.P.S.
Glasgow.Professor of Surgery, University of Glasgow.
"Gastro-Intestinal Hemorrhage."

October 13, 1953:

Symposium on Poliomyelitis.

Dr. J. D. Adamson, Dr. R. T. Ross,
Dr. J. A. Hildes, Dr. M. H. L. Desmarais.

November 10, 1953:

"Surgery of Congenital Heart Disease"

Dr. Colin C. Ferguson, Professor of Surgery, University
of Manitoba.

December 10, 1953:

"Toxic Reactions to Antibiotics"

Dr. J. M. Kilgour.

"Electrolyte and Fluid Therapy in Common Pediatric Conditions"
Dr. S. Israels.

"Use and Dangers of Oxytocics"
Dr. O. A. Schmidt.

January 15, 1954:
Clinical Programme at St. Boniface Hospital.

February 12, 1954:
"Ionizing Radiation and Cancer"
Dr. R. J. Walton, Director Radiotherapy,
Winnipeg General Hospital.

"Practical Aspects of Anticoagulant Therapy"
Dr. Paul T. Green.

March 11, 1954:
"Treatment of Peptic Ulcer From Point of View of Small Bowel"
Dr. A. J. Glazebrook, Director of Research,
St. Boniface Hospital.

"New Diets and Insulins in the Treatment of Diabetes"
Dr. J. P. Gemmell, Department of Medicine,
Winnipeg General Hospital.

April 6, 1954:
Special Meeting in conjunction with the Refresher Course.
"Medical Emergencies"
Dr. F. S. Brien, Professor of Medicine,
University of Western Ontario, London, Ontario.

April 19, 1954:
"Problems of the Canadian Medical Association and Health Insurance Outlook"
Dr. C. W. Burns.

The annual Refresher Course Programme arranged by the Committee on Post Graduate Studies (Faculty of Medicine, University of Manitoba), was held on April 12th to 15th inclusive. Sixty doctors attended and were enthusiastic in their commendation. Guest speakers were:

Dr. F. S. Brien, Professor of Medicine, University of Western Ontario, London, Ontario.

Dr. W. H. ReMine, Division of Surgery, Mayo Clinic, Rochester, Minnesota.

The Committee is grateful to all those who contributed to our programmes and it is felt that we have had a successful year.

Members of the Committee were: Dr. J. Doupe, Dr. Charles Hollenberg, Dr. James Hart, Ex. Officio, The President, Dr. David Swartz.

Their helpful co-operation is much appreciated.

Respectfully submitted.

R. E. Beamish,
Chairman.

Report from the Welfare Council of Greater Winnipeg, Health Division

To the President and Members of
The Winnipeg Medical Society:

The Welfare Council of Greater Winnipeg has continued the work of correlating the plans and work of 89 agencies and organizations of the community. Reports from the following groups were heard during the year:

Winnipeg League of Hard of Hearing.

Convalescent Hospital.

Cerebral Palsy Parents' Council.

Victorian Order of Nurses.

Manitoba Hospital Service Association.

Dr. M. Desmarais, Director of Physical Medicine at Winnipeg Municipal Hospitals gave a talk on Poliomyelitis, with special reference to rehabilitation.

Dr. Bruce Chown gave the Council an outline of Medical Research in Canada.

The value of joint health drives came in for considerable discussion throughout the year. It was also decided to initiate a review procedure which will help to prevent duplication of service and avoid excess costs.

A committee of the Canadian Welfare Council is working on a report on the financing and provision of health services for Canadians. A rough draft of the findings and recommendations of a sub-committee was presented to the Winnipeg Council, and it is hoped that this report will be made available to the medical profession when the final draft is completed.

Respectfully submitted.

Representative.

Marjorie Bennett,

Legislative Committee of Fifteen

To the President and Members of
The Winnipeg Medical Society:

No meeting of the Legislative Committee of 15 for 1953-1954 was held. Also no controversial legislation affecting the Medical Association was enacted.

Since the Manitoba Hospital Service Association is no longer confined to the City of Winnipeg, Bill No. 30, an Act to amend an Act was passed. The Amendment provides for changing the Constitution for the Board of Trustees for the Manitoba Hospital Service Association by substituting the Manitoba Medical Association for the Winnipeg Medical Society as the body empowered to nominate 3 members of the board.

Respectfully submitted.

H. Funk,
Chairman.

Library Report

To the President and Members of
The Winnipeg Medical Society:

During the past year, 45% of the city's physicians patronized the library, and borrowed 5,300 items, an increase of 28% over the previous year.

The library has been open week nights during the winter months. Eight book displays were given before meetings of the Society.

From the \$1,000.00 contributed to the library by the society, 31 books were bought, 79 volumes were bound, and students were paid a total of \$238.00 for library attendance in the evening hours.

Respectfully submitted.

Gerard Allison,
Representative.

Representative to Executive Committee Manitoba Medical Association

To the President and Members of
The Winnipeg Medical Society:

The past year has seen several interesting developments in connection with the Manitoba Medical Association.

In June, 1953, we were host to the Canadian Medical Association and judging by the comments from the visitors the meeting was a great success.

After considerable revision and discussion the new Manitoba Medical Fee schedule is in the hands of the printer, who has only been held up because of a dearth of ring binders. It is hoped to have these available soon.

Probably one of the most important developments was the presentation of a report from a special committee under Dr. Rabson, who brought in a report on the feasibility of providing group insurance for the doctors of Manitoba. In essence, it is proposed to provide \$15,000 of life insurance without evidence of insurability, to all doctors up to the age of 60, and \$7,500 to those between the ages of 60 and 70, the insurance terminating at 70. The policies will include a disability clause.

The probable cost will be in the neighborhood of 73c per thousand per month for those entering the plan at its inception who are under the age of 60. Higher rates will apply to those entering at age 60 to 65. The plan is dependent on a contribution from Manitoba Medical Service which

at present is expected to be 25c per thousand per month. This would reduce the cost of the insurance to 48c per thousand per month. This plan has been approved in principle by the M.M.A. executive and is now being considered by the M.M.S. executive.

Other important business under consideration but not yet finalized includes:

The erection of a memorial plaque in memory of the doctors who died in World War II.

The possibility of a pension scheme for doctors.

Automobile insurance at a fleet rate.

Many matters effecting the welfare of the profession in general were brought to the attention of the Executive and where necessary appropriate action was taken. I can assure you that you are very well served both by the executive, and the members of the various committees of the Manitoba Medical Association.

Respectfully submitted.

F. Hartley Smith,
Representative.

Representative to Manitoba Medical Review

To the President and Members of
The Winnipeg Medical Society:

As representative of the Winnipeg Medical Society to the Manitoba Medical Review, I wish to submit herewith my report for the Annual Meeting.

The Manitoba Medical Review has received each month a report of the meetings of the Winnipeg Medical Society and these have been published along with any other news of the Society which I felt was of interest. The Review has been more than co-operative in seeing that the affairs of the Winnipeg Medical Society have been given proper publicity.

The Review has been very anxious to publish any papers which have been read before the Winnipeg Medical Society but unfortunately it has proven very difficult to get any of the speakers to present their papers for publication.

All of which is respectfully submitted.

R. H. McFarlane,
Representative.

Community Chest of Greater Winnipeg

To the President and Members of
The Winnipeg Medical Society:

The doctors of Winnipeg contributed \$14,433.25 to the Community Chest Campaign of the Winnipeg Medical Society in 1953.

An innovation was attempted this year in canvassing the doctors of Winnipeg and their office assistants. Canvassing was done at the hospitals by groups of doctors' wives, and the response to this campaign was more than gratifying. Mrs. K. R. Trueman organized the team at the General Hospital and Maternity Pavilion; Mrs. L. R. Rabson and Mrs. R. O. Burrell organized St. Boniface Hospital and the Misericordia. Mrs. G. R. Diehl organized the team at the Grace Hospital, and Dr. B. E. Loadman organized the Children's Hospital. Miss Mollie Phair was in charge of employees in the doctors' offices, and great help was also obtained in this connection from Miss Pearl Brownell and her associates.

It is impossible to list all the doctors' wives who took part as canvassers, but to the above named people and to those who did participate, the greatest praise and gratitude is due for the success which we achieved.

Great credit is due to the doctors who contributed 35% more in 1953 than in 1952, but it is amazing to the undersigned that there are still many doctors who make no contribution at all to the Community Chest, and this is not related to income as our records readily show.

Herewith is copy of a letter received from Mr. Barbour, the Executive Director of the Community Chest:

"Dear Dr. Rabson:

"We are now assembling the statistics of the 1953 campaign and it is a pleasure to report to you that the total returns in the canvass of the physicians and surgeons of Greater Winnipeg in the recent successful campaign, were \$14,433.25, as against the 1952 total of \$10,738.10.

"Inasmuch as the overall increase from the campaign total of 1952 was 10%, your group's increase of nearly 35% undoubtedly one of the reasons why we went over the top. To you and your associates our sincere thanks and congratulations."

At the present time and under present conditions, I feel that the total reached in 1953 should represent a minimum from the doctors of this city, and I would urge my successors that it be set beyond this figure.

Respectfully submitted.

L. R. Rabson,
Chairman.

Section of Anaesthesiology

To the President and Members of
The Winnipeg Medical Society:

It is with pleasure that I offer the report of the Winnipeg Anaesthetists Society.

An agenda consisted of seven monthly meetings held at the Medical Arts Club Rooms. The programme was as follows:

October, 1953—Dr. R. Ridley of Rochester, Minn., spoke on "Anaesthesia for Cardio-Vascular Surgery."

November, 1953—Dr. D. Tass reported the Highlights of the State Convention.

December, 1953—A dinner and dance was held for the members and their wives.

January, 1954—Dr. W. Blair spoke on "Curare in Catarract Surgery." Dr. M. Bennett reported on the December Meeting of the New York Post Graduate Assembly.

February, 1954—The Winnipeg General Hospital presented "A Symposium on Succinyl Choline."

March, 1954—Dr. H. C. Hutchison presented a paper on "Rectal Pentothal."

April, 1954—"Interesting Cases" were presented by members from all the hospitals in the Winnipeg area.

May, 1954—This meeting will consist of a dinner on "Interesting Anaesthetic Gadgets."

The officers elected for the coming year are as follows:

Chairman, Dr. H. C. Hutchison.

Vice-Chairman, Dr. D. Tass.

Secretary-Treasurer, Dr. Bernadine Roe.

Programme Convener—Dr. L. Cruikshank.

Respectfully submitted.

David Tass,
Secretary.

Report From the Board of Trustees Manitoba Hospital Service Association

To the President and Members of
The Winnipeg Medical Society:

In the Fifteenth Annual Report of the Manitoba Hospital Service Association, Mr. F. D. MacCharles, Executive Director, states that 338,181 residents of Manitoba, or 43% of the population, are enrolled. Hospital accounts incurred in 1953 amounted to 87.3% of earned subscriptions. The provision for epidemics, emergencies, etc., has been increased to approximately one-half million dollars.

Increased subscription rates became effective January 1, 1954, and were made necessary by increasing costs of hospitalization and by increased benefits required in order to keep pace with modern hospital and medical practices. These include extended days of care, increased allowances for maternity care and drugs, allowance for certain diagnostic hospital procedures, limited care and treatment of nervous and mental patients.

In March, 1954, a circular letter was sent out by the Manitoba Medical Association to all practicing doctors in Manitoba.

The changes in contract benefits were listed in detail. The appointment of three new committees was reported:

1. A committee of six medical men to confer with M.H.S.A. on diagnostic procedures which might be covered in addition to those specified in the contract.

2. A committee of eight medical members to give technical advice in regard to liability in respect of borderline claims.

3. A committee of two medical specialists to act as a consulting committee to deal with borderline mental and nervous claims.

Respectfully submitted.

Marjorie Bennett,
Representative.

Medical History Section

To the President and Members of
The Winnipeg Medical Society:

This year the Medical History Section has undergone a revival. So far (April 9th) there have been four meetings, at the first of which Dr. Ross Mitchell was elected President.

The attendance has been reasonably satisfactory. The numbers have been large enough to reveal interest and small enough to permit intimate discussion. It is possible that more would attend if it were generally realized that membership in the Society carries with it membership in all sections, including ours, and that, as Sections are forbidden by the Constitution to levy extra dues, there is no extra fee.

The topics and the speakers have been: "Philately and Medicine," Paul Green; "The Golden Age of Anatomy in Edinburgh," Professor Thompson; "The Early Surgeons of the Hudson's Bay Company," Ross Mitchell; "An Evening with Montaigne," J. C. Hossack. There will be one more meeting in this season at which Simon Jauvois will speak on Culpeper and plants will be laid for next year.

Respectfully submitted.

J. C. Hossack,

Representative to the General Practitioners' Association of Manitoba

To the President and Members of
The Winnipeg Medical Society:

The General Practitioners' Association of Manitoba reports another successful year of progress. At their annual business meeting in October, 1953, held in conjunction with the annual convention of the Manitoba Medical Association, Dr. W. J. Boyd was elected president and Dr. Glen F. Hamilton, first vice-president. The Association's two annual cash prizes of \$150.00 each were awarded at the University Convocation in May, 1953, for excellence in internship in the two teaching hospitals.

A post-graduate course of lectures in internal medicine was held from January to April, 1954, and was attended by thirty registrants.

A very successful social evening, organized and managed by Dr. Jack Winestock, was held on February 13, 1954, and took the form of a dinner and Valentine Dance at the Glendale Country Club. This affair was attended by a large number of doctors and their wives and was not limited to General Practitioners but was thrown open to specialists and other lay forms of medical life.

A provincial chapter of the embryonic College of General Practice of Canada is being formed locally, and will be received into the College in June, 1954, at the C.M.A. convention in Vancouver. A minimum of twenty-five is required to form a chapter but the G.P.A.M. expects a much larger number than this.

These are only a few of the year's highlights. All in all, the G.P.A.M. is flourishing as the green bay tree flourishes.

Respectfully submitted.

Jack McKenty,
Representative.

Committee on Civilian Defence Medical Services

To the President and Members of
The Winnipeg Medical Society:

The committee, appointed by your Society, is composed of Doctor F. Hartley Smith, Doctor A. R. Tanner, Doctor J. T. MacDougall and Doctor J. L. Downey (Chairman) and other members added by Doctor George A. Waugh, Doctor Athol R. Gordon and Doctor P. K. Tisdale.

Terms of reference unchanged from 1952-53.

Following the explosion of the "H" bomb with its subsequent terrific devastation, Civilian Defence thinking changed from that of control to one of mass evacuation. Lacking any directive policy your committee continued on with its original planning, namely that of allocation and organization of medical staffs in selected urban hospitals and assignment of medical officers to twelve first aid stations. Our feeling is that these plans could be activated for any disaster and would certainly be used if any mass evacuation from another centre were to be directed to Winnipeg.

Regular meetings were infrequent and usually convened to acquaint the members with civilian defence proceedings gathered from the "grape-vine." No provincial policy was available for 1953-54 and as far as could be ascertained the office of the Director of Civilian Defence Health Services for the province was not functioning. Other business included the preparation of lists of physicians assigned to specific hospitals and keeping them up to date. Frequent informal discussions were held in relation to the work of the various members in their preparation of detailed physician assignment to hospital disaster plans acceptable to said hospitals medical staff executives. One hospital has rejected our proposals and consequently is covered in our planning only by a list of physicians available in time of disaster. This hospital is evidently working out its own scheme with the aid of the local hospital associations.

Doctor Athol Gordon developed an excellent procedure for identification of bodies. The documentation has been worked out and the co-operation of the Dentists and Jewellers organizations obtained.

Lecturers in special medical subjects were arranged for at the request of the Manitoba Division of the Canadian Red Cross and the Manitoba Civilian Defence Health Services.

Physicians were supplied to the "On Guard Canada" Civilian Defence Convoy Show in November, 1953.

Generally, everyone agrees that Civilian Defence is a fine thing, provided some one else does the job! Many physicians have indicated their willingness to do any job requested when and if the occasion arises but for the present, have no time nor inclination for active Civilian Defence work.

Under the prevailing conditions your committee recommends that, after the completion of present plans, master copies be filed with the executive council of the Winnipeg Medical Society, The Manitoba Medical Association and the Coordinator of Civilian Defence of the province and that this committee be dissolved.

May I express my personal appreciation for the co-operation and consideration received from the members of the committee.

Respectfully submitted.

Joe L. Downey,
Chairman.

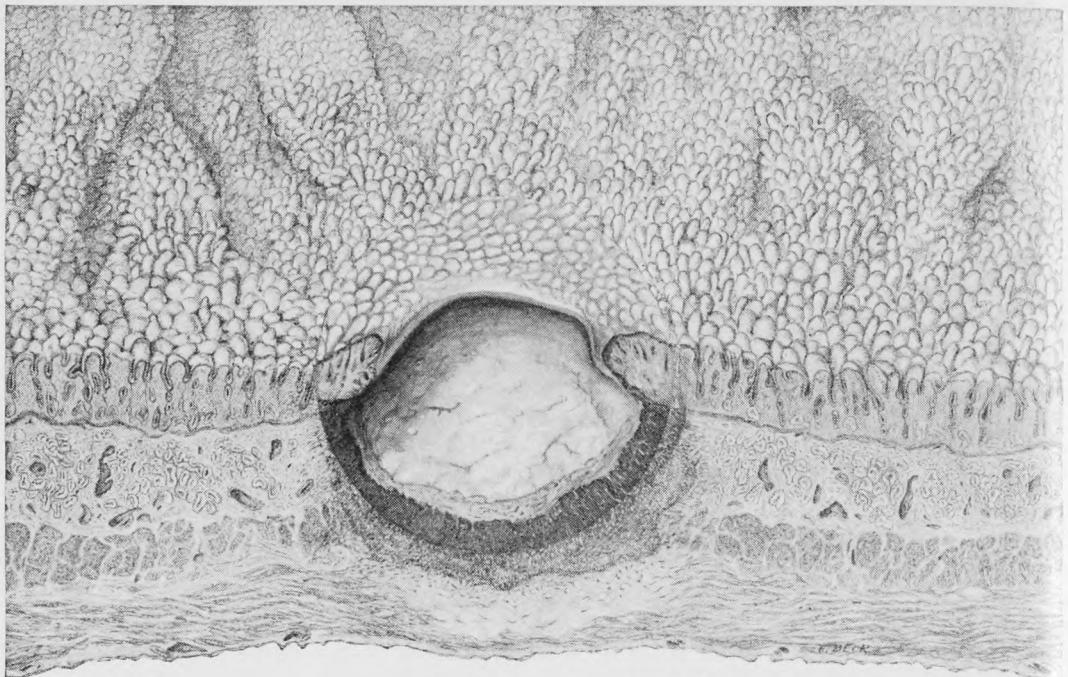
Eye, Ear, Nose and Throat Section

To the President and Members of
The Winnipeg Medical Society:

The Section has had two meetings in the past year. The membership in the Section now totals 30. There are no outstanding events or problems to report.

Respectfully submitted.

W. C. Guest,
Secretary.



Cross section of active duodenal ulcer.

Dramatic Remission of Ulcer Pain

Pain of ulcer is associated with hypermotility; the pain is relieved when abnormal motility is controlled by Pro-Banthine.®

“In studying¹ the mechanism of ulcer pain, it is obvious that there are at least two factors which must be considered: namely, hydrochloric acid and motility.

“... our studies indicate that ulcer pain in the uncomplicated case is invariably associated with abnormal motility....

“Prompt relief of ulcer pain by ganglionic blocking agents . . . coincided exactly with cessation of abnormal motility and relaxation of the stomach.”

Pro-Banthine (β -diisopropylaminoethyl xanthene-9-carboxylate methobromide, brand of propantheline bromide) is a new, improved, well tolerated anticholinergic agent which consistently reduces hypermotility of the stomach and intestinal tract. In peptic ulcer therapy² Pro-Banthine has brought about dramatic remissions, based on roentgenologic evidence. Concurrently there is a reduction of pain or, in many instances, the pain

and discomfort disappear early in the program of therapy.

One of the typical cases cited by the authors² is that of a male patient who refused surgery despite the presence of a huge crater in the duodenal bulb.

“This ulcer crater was unusually large, yet on 30 mg. doses of Pro-Banthine [q.i.d.] his symptoms were relieved in 48 hours and a most dramatic diminution in the size of the crater was evident within 12 days.”

Pro-Banthine is proving equally effective in the relief of hypermotility of the large and small bowel, certain forms of pylorospasm, pancreatitis and ureteral and bladder spasm. G. D. Searle & Co., Research in the Service of Medicine.

1. Ruffin, J. M.; Baylin, G. J.; Legerton, C. W., Jr., and Texter, E. C., Jr.: Mechanism of Pain in Peptic Ulcer, *Gastroenterology* 23:252 (Feb.) 1953.
2. Schwartz, I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: A Clinical Evaluation of a New Anticholinergic Drug, Pro-Banthine, *Gastroenterology* 25:416 (Nov.) 1953.

Section of Internal Medicine

To the President and Members of
The Winnipeg Medical Society:

During the period 1953-54 this section held two meetings. 1. June, 1953; Dr. W. M. Hammon spoke on Poliomyelitis and the use of Gamma Globulin.

2. February 3, 1954; Dr. L. Israels spoke on "The Immunological Aspects of Thrombocytopenia and Leukopenia."

At the February, 1954, meeting the following officers were accepted for the year 1954-55.

Chairman, Dr. L. G. Bell

Secretary-Treasurer, Dr. R. A. Polson

Programme Committee Chairman, Dr. E. N. East

All of which is respectfully submitted.

A. E. Thomson,
Secretary.

Paediatric Section

To the President and Members of
The Winnipeg Medical Society:

During the year your Paediatric Section held one Scientific Meeting at the Children's Hospital. Dr. R. J. Wilson of the Connaught Laboratory was in Winnipeg at the Public Health Meeting. We arranged for a brief resume of the current status of the various inoculations provided by the Laboratory for use in prevention of Diphtheria, Whooping Cough, etc. This meeting was attended by members of the Society and Interns at the Children's Hospital.

In addition to this, communication has been held with the Manitoba Medical Association concerning the fees and fee schedules for Paediatricians.

We have been unable to arrange for a representation to the Association from our group, and have been informed that the Committee charged with the responsibility of the revision of fees are concerned with "a minimum fee for medical practice" (This schedule takes no cognizance of specialist attention or special circumstances). The Paediatric Section have not been represented on this Committee.

This report is respectfully submitted.

M. McLandress,
Secretary.

Public Relations

To the President and Members of
The Winnipeg Medical Society:

No special problems have arisen in the past year. The Manitoba Medical Association and Manitoba Medical Services have sponsored a series of 39 popular medical broadcasts over CKY each Sunday afternoon at 4.45 p.m.

Tentative plans have been made for an address to the Winnipeg Medical Society next fall by a British physician, on the reasons he has left the British Medical Scheme to settle in Canada. A press report on this address should aid the cause of free medicine.

Respectfully submitted.

F. G. Allison,
Representative.

Radiological Section

To the President and Members of
The Winnipeg Medical Society:

Total membership for the year was 18, including members and members-elect. Two formal business meetings were held in the past year.

One of our members, R. A. Macpherson, had the honour of being the President of the Canadian Association of Radiologists during the past year.

Respectfully submitted.

M. K. Kiernan,
Secretary.

Benevolent Fund

To the President and Members of
The Winnipeg Medical Society:

The following brief review of the contributions and disbursements of "The Benevolent Fund" since its inception, May 1947, will be of interest to the members:

1947—Contributions, \$1,125.00 by 9 members.

Total membership, 384; 2.3% contributing.

Average contribution, \$125.00.

Disbursements, none.

1948—Contributions, \$1,406.00 by 93 members.

Total membership, 370; 25.1% contributing.

Average contribution, \$15.12.

Disbursement of \$625.00 to 3 individuals.

1949—Contributions of \$250.00 by 18 members.

Total membership, 370; 4.8% contributing.

Average contribution, \$13.80.

Disbursements of \$80.00 to 2 individuals.

1950—Contributions of \$582.00 by 48 members.

Total membership, 370; 12.9% contributing.

Average contribution, \$12.12.

Disbursements, \$423.70 to 3 individuals.

1951—Contributions of \$358.00 by 23 members.

Total membership, 434; 5.3% contributing.

Average contribution, \$15.22.

Disbursements, \$369.33 to 3 individuals.

1952—Contributions of \$1,665 by 154 members.

Total membership, 369; 41.7% contributing.

Average contribution, \$10.80.

Disbursements, \$344.33 to 2 individuals.

1953—Contributions of \$1,251 by 122 members.

Total membership, 369; 33% contributing.

Average contributions, \$10.25.

Disbursements, \$1,559.00 to 3 individuals.

It should be our aim to build as large a reserve as possible. To date, 41% of the members have contributed at least once. We feel that this percentage should be increased to include an annual contribution from everyone.

Respectfully submitted.

R. A. Macpherson,
Chairman.

* * *

To the President and Members of
The Winnipeg Medical Society:

The Benevolent Fund Committee of the Winnipeg Medical Society has held three meetings in the 1953-54 term. The Committee during this time has administered the Benevolent Fund with grants to one retired physician and the widows of three other doctors. The amount contributed by the Fund is indicated in the Treasurer's report.

At the second meeting of the Committee, Dr. Sam Boyd indicated that he would introduce a motion to the Winnipeg Medical Society concerning the composition of the Committee. Recently the Committee has been composed only of Past Presidents of the Society. Dr. Boyd's motion will be an amendment to the Constitution to the effect that the Committee in charge of the Benevolent Fund be composed of the most recent five Past Presidents of the Medical Society, the immediate Past President automatically to replace the most senior member of the Committee.

Respectfully submitted.

K. R. Trueman,
Secretary.

Benevolent Fund

To the President and Members of
The Winnipeg Medical Society:

The following report of the Society's Auditors, Messrs. Thornton, Milne & Campbell, is presented by Dr. S. A. Boyd, Treasurer:

With G-E diagnostic x-ray units, you can
start small . . .

build big!

ONE of the three General Electric diagnostic units shown here will give you the results you have a right to expect within the range of service you need. All provide modern radiographic and fluoroscopic facilities . . . each is built to the exacting standards naturally associated with General Electric.

And remember — you can get any of these units — *with no initial investment* — under the G-E Maxiservice® rental plan. What's more, if you want to upgrade or "trade-in" your rented unit, there's no obsolescence loss.

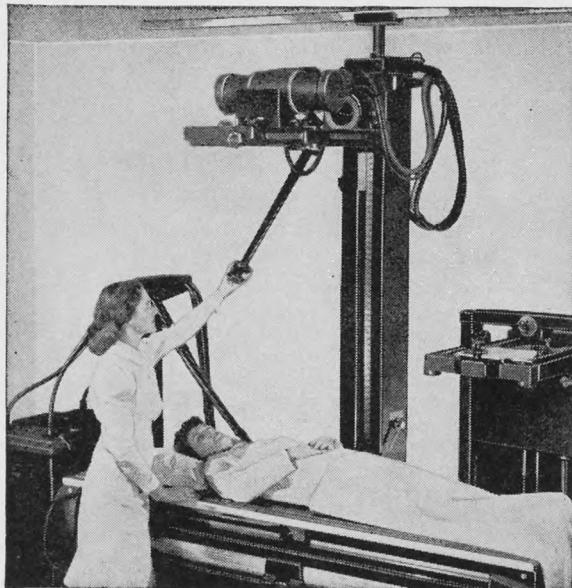
Get all the facts from your G-E x-ray representative.



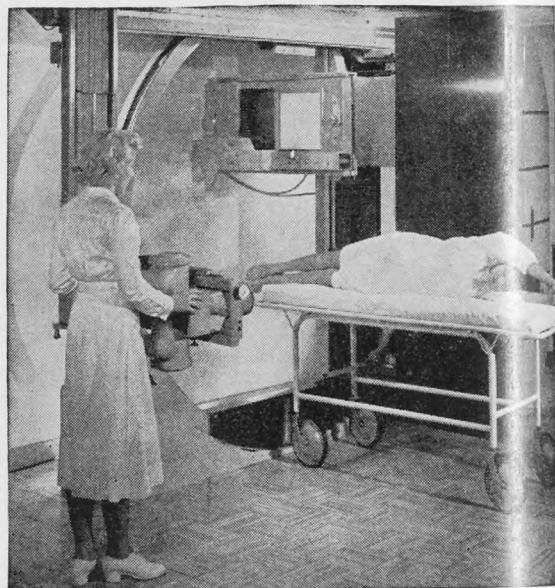
MAXICON line can be built up a step at a time. Add components as you need them.

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MAXISCOPE® gives you every feature you've sought in conventional x-ray apparatus — fast, consistent results for both radiography and fluoroscopy.



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5th May, 1954.

To the Members,
The Winnipeg Medical Society Benevolent Fund,
Winnipeg, Manitoba.

Dear Sirs:

We have examined the accounts of the fund for the year ended 30th April, 1954, and submit herewith our statement pertaining thereto:

Balance, 30th April, 1953	\$2,937.59
Add:	
Receipts for the year	1,352.00
Bond Interest	45.00
	<hr/>
	\$4,334.59
Less:	
Disbursements	1,470.42
	<hr/>
Balance, 30th April, 1954	\$2,864.17

Represented by:

Cash on deposit with The Bank of Toronto	\$1,397.92
Govt. of Canada Bonds, 3% 1966	
Par Value \$1,500.00 (Market Value \$1,490.62) Fully Regis- tered in name of Fund—at cost	1,466.25
	<hr/>
	\$2,864.17

Donations received are in accordance with duplicate receipts examined by us. All disbursements made were under the signatures of authorized signing officers of the fund.

We obtained from The Bank of Toronto verification of the bank balance, subject to allowance for outstanding cheques as shown by the books.

The securities are held in a safety deposit box and were presented for our examination. All interest has been accounted for on a received basis.

Yours very truly,
THORNTON, MILNE & CAMPBELL,
Chartered Accountants.

Obituary

Dr. William Edwin Raymond Coad

Dr. William Edwin Raymond Coad, aged 81, died in the Princess Elizabeth Hospital, Winnipeg, on February 17, 1954, from carcinoma of the thyroid gland.

Upon retirement from practise in 1938, Dr. Coad became Curator of the Museum, Department of Pathology, Faculty of Medicine, University of Manitoba. Until 1952 he was active in making the Museum useful for teaching by his clinical history summaries, sorting and re-allocating specimens which he classified and arranged to conform with the "Standard Nomenclature of Disease"—before this system was in use in the Medical Record Departments of any of the Winnipeg Hospitals. In 1947 he had the onerous duty of moving all the specimens from 2 large to 5 smaller rooms for group teaching. Through his efforts the Museum has been raised to an effective instrument of medical instruction the equal of any on this continent.

During his period of active surgical practice in Winnipeg, 1923 to 1938, he was Lecturer in Surgery, Faculty of Medicine, University of Manitoba and Clinical Assistant in the Surgical Departments at the Winnipeg General Hospital and at Grace Hospital. It is said that as Secretary to the Surgeons' Club of Winnipeg, the reading of Dr. Coad's minutes often gave a more lucid account of the subject than did the main speaker's original

presentation. Dr. Coad showed his public interest by his work in committees of important organizations, Honorary Secretary of the Manitoba Medical Association, Member of the College of Physicians and Surgeons Council and their representative on the Senate of the University of Manitoba. He was made a life member of the College of Physicians and Surgeons in 1941 and of the Winnipeg Medical Society in 1945.

He was a great golf and curling enthusiast and to establish good relations and provide recreation, he was active in organizing these games for the medical profession.

Born in Huron County, Ontario, he graduated with the M.B. degree in 1897 and the M.D. in 1898 from Trinity College, University of Toronto, then came West and practised for 18 years at Franklin, Manitoba. He answered the call for doctors during the war by enlisting in the C. A. M. C., 1916 to 1919 and most of this time he was attached to No. 13 Canadian General Hospital overseas. This service was followed by 2½ years post-graduate training. He was granted the F.R.C.S. (Edin.) degree in 1923 after which he began the practise of Surgery in Winnipeg.

He possessed the qualities required for the best type of physician and along with these he had a charming and agreeable personality. His career is unique in the great contribution he made as Curator of the Medical Museum after he had retired from active practise at the age of 66.

when the diagnosis is

ALLERGIC DERMATITIS

USE

histocaine

*E.B.S.

Histocaine E.B.S. is the ointment of choice because it may be safely used for treating a wide range of skin conditions, both systemic and local. Its ingredients are such as to provide the following actions: relief from itching, reversal of allergic manifestation, local anaesthesia, antisepsis. The water-soluble base is easily removed, literally dissolving in a stream of water. Histocaine does not soil clothing.

HISTOCOCAINE CONTAINS: Camphor, Menthol, Calamine, Benzocaine and Pyranisamine Maleate in a water-soluble base.

INDICATIONS: Burns (thermal & solar), insect bites, poison ivy, contact dermatitis, allergic pruritus, and allergic skin reactions in general.

Available in one ounce tubes and one pound jars.

*SAMPLE SUPPLIED ON REQUEST



E. B. Shuttleworth Limited
TORONTO CANADA

Department of Health and Public Welfare

Comparisons Communicable Diseases — Manitoba (Whites and Indians)

DISEASES	1954		1953		Total	
	Mar. 21 to Apr. 17, '54	Feb. 21 to Mar. 20, '54	Mar. 22 to Apr. 18, '53	Feb. 22 to Mar. 21, '53	Jan. 1 to April 17, '54	Jan. 1 to Apr. 18, '53
Anterior Poliomyelitis	5	6	1	10	25	23
Chickenpox	140	182	62	114	701	500
Diphtheria	0	0	0	0	0	3
Diarrhoea and Enteritis, under 1 yr.	9	14	5	10	45	27
Diphtheria Carriers	0	0	0	0	0	0
Dysentery—Amoebic	0	0	0	0	0	0
Dysentery—Bacillary	6	1	0	1	10	3
Erysipelas	3	3	5	4	10	14
Encephalitis	1	0	0	0	1	0
Influenza	14	7	57	36	32	106
Measles	40	155	234	341	333	1813
Measles—German	3	1	1	6	9	19
Meningococcal Meningitis	1	0	2	6	3	13
Mumps	151	197	76	107	560	498
Ophthalmia Neonatorum	0	0	0	0	0	0
Puerperal Fever	0	0	0	0	0	0
Scarlet Fever	60	63	27	29	254	162
Septic Sore Throat	3	11	3	3	22	8
Smallpox	0	0	0	0	0	0
Tetanus	0	0	0	0	0	0
Trachoma	0	0	0	0	0	0
Tuberculosis	39	51	61	53	128	184
Typhoid Fever	0	0	0	0	2	0
Typhoid Paratyphoid	0	0	0	0	0	0
Typhoid Carriers	0	0	0	0	0	0
Undulant Fever	0	1	1	0	1	1
Whooping Cough	12	11	9	5	32	38
Gonorrhoea	117	100	60	72	413	326
Syphilis	9	7	3	11	27	23
Infectious Jaundice	43	28	40	40	117	114
Tularemia	0	0	0	1	0	1

Four-week Period March 21st to April 17th, 1954

*DEATHS FROM REPORTABLE DISEASES

For the Month of April, 1954

DISEASES	*809,000 Manitoba	*861,000 Saskatchewan	*3,825,000 Ontario	2,952,000 Minnesota
(White Cases Only)				
*Approximate population.				
Anterior Poliomyelitis	5	1	2	7
Chickenpox	140	208	2030	—
Diarrhoea and Enteritis, under 1 yr.	9	1	—	—
Diphtheria	—	1	—	—
Diphtheria Carriers	—	—	—	—
Dysentery—Amoebic	—	—	—	—
Dysentery—Bacillary	6	1	27	3
Encephalitis Epidemica	1	—	—	—
Erysipelas	3	2	2	—
Influenza	14	—	41	13
Infectious Jaundice	43	33	118	251
Measles	40	19	1227	82
German Measles	3	20	131	—
Meningitis Meningococcus	1	1	7	1
Mumps	151	638	1362	—
Ophthal. Neonat.	—	—	—	—
Puerperal Fever	—	—	—	—
Scarlet Fever	60	55	686	195
Septic Sore Throat	3	66	9	62
Smallpox	—	—	—	—
Tetanus	—	—	—	—
Trachoma	—	—	—	—
Tuberculosis	—	—	—	—
Tularemia	39	41	96	122
Typhoid Fever	—	—	3	3
Typh. Para-Typhoid	—	—	2	—
Typhoid Carriers	—	—	—	—
Undulant Fever	—	1	4	18
Whooping Cough	12	11	198	32
Gonorrhoea	117	—	202	—
Syphilis	9	—	54	—

Urban—Cancer, 50; Pneumonia, Lobar (490) 1; Pneumonia (other forms), 7; Poliomyelitis, 1; Syphilis, 1; Tuberculosis, 1. Other deaths under 1 year, 23. Other deaths over 1 year, 216. Stillbirths, 15. Total, 254.

Rural—Cancer, 30; Influenza, 1; Measles, 1; Pneumonia, Lobar (490) 1; Pneumona (other forms), 7; Tuberculosis, 1; other diseases attributable to viruses, 1. Other deaths under 1 year, 20. Other deaths over 1 year, 162. Stillbirths, 11. Total, 193.

Indians—Pneumonia, Lobar (490) 1; Diarrhoea and Enteritis, 1. Other deaths under 1 year, 2. Other deaths over 1 year, 2. Stillbirths, 1. Total, 5.

Morbidity due to communicable diseases is at quite a low ebb with the exception of chickenpox and mumps.

Poliomyelitis at present shows no signs of an epidemic to occur later, but it is too early in the year to make any forecast!

Scarlet Fever and septic sore throat are slightly increased.

Venereal Diseases also slightly increased.

Virus Diagnostic Facilities Available in Manitoba

J. C. Wilt, M.D., L. P. Lansdown, M.D.,
Maxwell Bowman, M.D.

An increasing demand by the physicians of this Province for adequate virus diagnostic facilities has followed the two major poliomyelitis epidemics; during recent years other virus diseases have also become of greater concern to the practitioner.

In answer to these demands a Public Health Grant has now been obtained and it is proposed to use it:

First—to develop virus diagnostic procedures in this community.

Second—to carry out some **applied** research in different virus diseases.

This investigation will be carried on through the Department of Bacteriology and Immunology, Medical Buildings, of the University of Manitoba, the Bacteriological Laboratory of the Winnipeg General Hospital and the Provincial Laboratory.

The initial work in poliomyelitis virus diagnostic procedures, using accepted tissue culture methods, is already well established; it is planned soon to apply methods for the isolation and identification of the Coxsackie virus.

As equipment and trained personnel become available the two projects already under way will be expanded and it is hoped to initiate still other projects in future years.

This article is submitted for publication in order:

First—to notify practicing physicians that virus diagnostic procedures are already available to practicing physicians in this province.

Second—that, in order to ensure the success, the expansion and the continuation of the service an adequate number of specimens must be submitted for examination by the practitioners.

Third—to submit to the practitioners an outline of the types of virus diseases in which these diagnostic facilities would be of value.

Fourth—(a) to stress the type of material that should be submitted to the Laboratory for the identification of a particular virus disease, and

(b) the method to be followed by the physician for the collection and submission to the Laboratory of each type of specimen required.

Virus Diseases of the Central Nervous System (1)

(a) Poliomyelitis—

Two stool samples early in the disease.

Two blood samples; one early in the disease; one two weeks later.

(b) Coxsackiosis—

Two stool samples early in the disease.

Two blood samples; one early in the disease; one two weeks later.

- (c) Encephalitis—i.e.: Western Equine—
Two blood samples: one early in the disease; one two weeks later.
- (d) Lymphocytic choriomeningitis—
Two blood samples: one early in the disease; one two weeks later.
- (e) Encephalitis as a complication of an infectious disease, i.e., mumps, herpes simplex.
Two blood samples: one early in the disease; one two weeks later.
Scrapings with curette from base of skin lesions placed on slide and spread thinly.

Virus Disease of the Respiratory System (2)

(a) Influenza—

Two blood samples: one early in the disease; one two weeks later. These will be typed.
Influenza A, A₁; B, B₁.

(b) Atypical pneumonia—

Two blood samples: one early in the disease; one two weeks later.

(c) Unusual pneumonias—

Two blood samples: one early in the disease; one two weeks later.

Virus Diseases of the Skin and Mucous Membrane (3)

(a) Conjunctivitis or keratitis—

Curettings from infected areas spread thinly on slide, allowed to dry, then shipped.

(b) Cowpox lesions on milker's hands—

Curettings from the base of the lesion spread thinly on slides, allowed to dry, then shipped.

(c) Unusual herpes simplex lesions—

Curettings from base of lesion spread thinly on slides, allowed to dry, then shipped.

Rickettsial Diseases (4)

(a) Rickettsialpox and Rocky Mountain Spotted Fever—
Fever probably occur here. Two blood samples: one early in the disease; one two weeks later.

(b) Typhus fever—probably occurs here as a recurrence only.

Two blood samples: one early in the disease; one two weeks later.

It is requested that the following information be supplied by the physician with each specimen submitted.

(1) A short history of the case sufficient to place the infection in one of the four groups listed.

(2) Date of onset of the infection.

Blood samples are collected and submitted to the Provincial Laboratory in the same manner as for the serologic test for syphilis.

Stool specimens are submitted to the Provincial Laboratory; the same technique is used as for the collection of stool specimens for the diagnosis of typhoid fever.

Scrapings from the base of a skin lesion or from the conjunctiva should be placed on a slide.

spread thinly, dried and submitted to the Laboratory, using the same method for submission of the specimen as for the submission of films of N. gonorrhoeae.

Reports on all specimens received, are sent without charge, to the physician who submitted the specimen, within two to three days following receipt of the second sample. The physician will be notified in advance when the second specimen required for completion of the particular test is to be submitted.

Summary

Preliminary work has already been carried out in Manitoba to develop virus diagnostic procedures. A Public Health Grant has been obtained

with which to expand this work.

The proposed virus diagnostic service is being established at the request of the practitioners in Manitoba.

The success and continuation of these facilities and services depends upon the submission by the practitioners of an adequate number of specimens obtained from cases of suspected virus infections.

Two textbooks dealing with virus infections are highly recommended for the practicing physician:

(1) Thomas M. Rivers. "Viral and Rickettsial Infections of Man."

(2) A. J. Rhodes and C. E. van Rooyen. "Textbook of Virology."

Department of Health and Public Welfare Province of Manitoba

Free Biological Products

The medical profession should be aware of the fact that along with other Civil Service offices, the above will be closed on Saturdays from May 1st to December 31st inclusive.

Orders should be placed before 5 p.m. on Fridays. In case of emergency on Saturday or Sunday telephone Dr. Maxwell Bowman at his residence, 3-4176. If no answer telephone Brathwaites Limited at 92-7391 during business hours, after business hours 44-4657 or 72-3021, for Connaught Products, and Parke Davis and Company for theirs at 3-5487.

Syphilis

1. An all time low rate was established in each of the last five successive years.

2. There still remains an undetermined reservoir of infection within provincial borders and an influx occurs periodically from without.

3. The brilliant success achieved should not prejudice eventual success by a spirit of over optimism and relaxation of interest.

Gonorrhoea

The decline shown for reported gonorrhoea is far less pronounced than for syphilis, even though the treatment for gonorrhoea is fully as effective. There are strong reasons to suspect the reporting of gonorrhoea to be inadequate and that statistics reveal trends rather than the true picture. Not reporting gonorrhoea cases and contacts as provided for under "The Public Health Act" has a serious attendant evil in that those contacts are not investigated but continue to spread disease.

PROVINCE OF MANITOBA

S Y P H I L I S

Reported Per 100,000 Population

Year	Total Cases	Average Age	Deaths	Congenital
1944	90.57	35	8.0	3.0
1945	85.32	31	7.5	1.5
1946	93.40	29	4.5	2.8
1947	81.70	37	5.4	1.9
1948	65.78	39	4.0	0.9
1949	52.20	42	3.6	0.9
1950	29.56	44	1.8	0.5
1951	20.59	47	1.7	0.4
1952	14.40	47	0.8	0.1
1953	11.30	49	1.9	0.1

GONORRHOEA

	Total Discovery By:	Reported Per 100,000 Population	
		Premarital Blood Tests	Police Cases at V. D. Clinic
(Oct. 1-Dec. 31)	—	11	237
	—	31	320
	19	14	327
	40	19	260
	50	14	195
	38	17	183
	25	1	166
	10	1	165
	8	0	160
	9	0	158

*The lower the average age the greater the number of newly acquired or congenital cases. These are highly infectious though usually not crippling or fatal.

The higher the average age the fewer new infections. The duration of disease may be anywhere from 5 to 30 years or more. This type may simulate almost any known disease. It is usually non-infectious, is commonly crippling and at times fatal.



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Victorian Order of Nurses

Home Care Plan

Last month this column made reference to the only Hospital Home Care Plan in Canada, which is in connection with the Reddy Memorial Hospital, Montreal.

During the past month we received a copy of the annual report of the Hospital and the Section on Home Care provides interesting information. We find that the total patient days under Home Care was the very large number of 12,588, almost exactly 25% of the number of patient days spent within the walls of the hospital. This is an excellent way to help alleviate the shortage of hospital beds, and to cope with the shortage of nurses.

The advantages and disadvantages of the plan are set forth, and one can only conclude that the advantages to both patient and family doctor, as well as to the hospital, outweigh the disadvantages.

We were interested to note that the patient remains in hospital only as long as the attending physician thinks it is necessary. While at home, visits and complete supervision are maintained by the hospital staff and by the Victorian Order of Nurses acting under the instructions of the medical director in public ward patients, and by the patient's own physician in private and semi-private cases. The services of a hospital interne are available to the patient at all times and in any emergency the patient has priority for re-admission to hospital wards. A complete hospital record is kept of the patient's progress. The interne's duties are similar to those of an interne in hospital, i.e., he does blood counts, urinalyses, abdominal paracentesis, obtains specimens for blood cultures, removes plaster casts, gives transfusions, makes routine physical examinations, all of which are recorded on the Home Care Case Record which is kept **in a file in the hospital**.

It was stated that the medical director of the service, Dr. Robbins, had addressed large meetings in other provinces and it was evident that hospital administrators in both eastern and western sections of the country were deeply interested in this subject of home care.

The Victorian Order of Nurses in Winnipeg has followed with great interest the development of hospital home care in Montreal where the nursing service for patients on the home care plan is bought by the hospital from the Victorian Order of Nurses at cost, on a per visit basis.

We realize that a hospital home care plan would be initiated by a hospital rather than the Victorian Order of Nurses, but we would be happy to pass along any information we have on this subject which is attracting increasing interest throughout Canada.

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